

# Plan Overview

SALUD HMO Y MÁS

30/20% (\$2,500 / \$5,000)

| Benefit description                                                                                                                                                        | Member responsibility                       |                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------|
|                                                                                                                                                                            | HEALTH NET SALUD NETWORK (CA)               | SIMNSA NETWORK (MEXICO MEMBERS; SELF-REFERRAL FOR CA MEMBERS) <sup>1</sup> |
| <b>Plan maximums</b>                                                                                                                                                       |                                             |                                                                            |
| Out-of-pocket maximum (combined with Rx) (Individual / Family) <sup>2</sup>                                                                                                | \$2,500 / \$5,000                           | \$1,500 / \$4,500                                                          |
| <b>Facility deductible</b>                                                                                                                                                 |                                             |                                                                            |
| Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family) | N/A / N/A                                   | N/A / N/A                                                                  |
| <b>Professional services</b>                                                                                                                                               |                                             |                                                                            |
| PCP Office visit <sup>3</sup>                                                                                                                                              | \$30                                        | \$5                                                                        |
| Specialist Office visit <sup>3</sup>                                                                                                                                       | \$50                                        | \$5                                                                        |
| Preventive care services <sup>3</sup>                                                                                                                                      | \$0                                         | \$0                                                                        |
| Telehealth services through the Select Telehealth Services Provider <sup>4</sup>                                                                                           | \$0                                         | Not Covered                                                                |
| Rehabilitation therapy <sup>5</sup>                                                                                                                                        | \$30                                        | \$5                                                                        |
| X-ray procedures <sup>3</sup>                                                                                                                                              | \$15                                        | \$0                                                                        |
| Laboratory procedures <sup>3</sup>                                                                                                                                         | \$15                                        | \$0                                                                        |
| Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)                                                                                                        | 20%                                         | \$0                                                                        |
| <b>Facility services</b>                                                                                                                                                   |                                             |                                                                            |
| Outpatient services (hospital)                                                                                                                                             | 20%                                         | \$0                                                                        |
| Outpatient services (ambulatory surgery center)                                                                                                                            | 20%                                         | \$0                                                                        |
| Inpatient hospital                                                                                                                                                         | 20%                                         | \$0                                                                        |
| Skilled nursing facility (100 day maximum)                                                                                                                                 | Days 1-10: \$0<br>Days 11-100: \$25 per day | \$0                                                                        |
| <b>Emergency services</b>                                                                                                                                                  |                                             |                                                                            |
| Urgent care services                                                                                                                                                       | \$30                                        | \$10                                                                       |
| Emergency room facility                                                                                                                                                    | \$200                                       | \$10                                                                       |
| Ambulance services (ground and air)                                                                                                                                        | \$200                                       | \$0 (air ambulance not covered)                                            |
| <b>Mental health and substance use disorder services</b>                                                                                                                   |                                             |                                                                            |
| Outpatient office visit                                                                                                                                                    | \$30                                        | \$5                                                                        |
| Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)                                                                            | 20%                                         | \$0                                                                        |
| Inpatient                                                                                                                                                                  | 20%                                         | \$0                                                                        |
| <b>Other services</b>                                                                                                                                                      |                                             |                                                                            |
| Durable medical equipment <sup>3</sup>                                                                                                                                     | \$0                                         | \$0                                                                        |
| Diabetic equipment                                                                                                                                                         | \$0                                         | \$0                                                                        |
| Acupuncture services <sup>6</sup>                                                                                                                                          | Rider available                             | Not Covered                                                                |
| Chiropractic services <sup>6</sup>                                                                                                                                         | Rider available                             | Not Covered                                                                |

(Continued)

<sup>1</sup>Out-of-network providers, facilities or pharmacies in Mexico (other than those in the SIMNSA Network) are not covered by this plan.

<sup>2</sup>The OOPM is combined for the Health Net Salud network in California and the SIMNSA network in Mexico.

<sup>3</sup>Preventive care services are covered for children and adults based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

<sup>4</sup>Listed cost share is for services provided through the Select Telehealth Services Provider; for all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.

<sup>5</sup>Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

<sup>6</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit in all Salud HMO y Mas plans.

**This is merely a brief summary of benefits. It does not include all covered services, limitations or exclusions. Please refer to the Certificate of Insurance for all terms and conditions of coverage.**

Salud con Health Net HMO is offered by Health Net of California, Inc., a subsidiary of Health Net, LLC and Centene Corporation. Providers in the Health Net Salud Network (Salud Network) have been selected to provide services to members of this plan who live in California. A network of physicians contracting with Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) has been selected to provide services in Mexico. Health Net and Salud con Health Net are registered service marks of Health Net, LLC. All rights reserved.