

# Plan Overview

SALUD HMO Y MÁS  
20/500/10% (\$3,500 / \$7,000)

| 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>                                                                                                | \$3,500 / \$7,000             | \$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) | \$500 / \$1,000               | N/A / N/A                                                                  |
| <b>Professional services</b>                                                                                                                                               |                               |                                                                            |
| PCP Office visit <sup>3</sup>                                                                                                                                              | \$20 deductible waived        | \$5                                                                        |
| Specialist Office visit <sup>3</sup>                                                                                                                                       | \$40 deductible waived        | \$5                                                                        |
| Preventive care services <sup>3</sup>                                                                                                                                      | \$0 deductible waived         | \$0                                                                        |
| Telehealth services through the Select Telehealth Services Provider <sup>4</sup>                                                                                           | \$0 deductible waived         | Not Covered                                                                |
| Rehabilitation therapy <sup>5</sup>                                                                                                                                        | \$20 deductible waived        | \$5                                                                        |
| X-ray procedures <sup>3</sup>                                                                                                                                              | \$10 deductible waived        | \$0                                                                        |
| Laboratory procedures <sup>3</sup>                                                                                                                                         | \$10 deductible waived        | \$0                                                                        |
| Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)                                                                                                        | 10% deductible waived         | \$0                                                                        |
| <b>Facility services</b>                                                                                                                                                   |                               |                                                                            |
| Outpatient services (hospital)                                                                                                                                             | 10% deductible applies        | \$0                                                                        |
| Outpatient services (ambulatory surgery center)                                                                                                                            | 10% deductible applies        | \$0                                                                        |
| Inpatient hospital                                                                                                                                                         | 10% deductible applies        | \$0                                                                        |
| Skilled nursing facility (100 day maximum)                                                                                                                                 | 10% deductible applies        | \$0                                                                        |
| <b>Emergency services</b>                                                                                                                                                  |                               |                                                                            |
| Urgent care services                                                                                                                                                       | \$20 deductible waived        | \$10                                                                       |
| Emergency room facility                                                                                                                                                    | \$200 deductible applies      | \$10                                                                       |
| Ambulance services (ground and air)                                                                                                                                        | \$200 deductible waived       | \$0 (air ambulance not covered)                                            |
| <b>Mental health and substance use disorder services</b>                                                                                                                   |                               |                                                                            |
| Outpatient office visit                                                                                                                                                    | \$20 deductible waived        | \$5                                                                        |
| Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)                                                                            | 10% deductible waived         | \$0                                                                        |
| Inpatient                                                                                                                                                                  | 10% deductible applies        | \$0                                                                        |
| <b>Other services</b>                                                                                                                                                      |                               |                                                                            |
| Durable medical equipment <sup>3</sup>                                                                                                                                     | \$0 deductible waived         | \$0                                                                        |
| Diabetic equipment                                                                                                                                                         | \$0 deductible waived         | \$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.