

Plan Overview NG

HRA 3000 – ACY (BIE)¹

Benefit description	Insured person(s) responsibility	
	In-network ²	Out-of-network ³
All benefits including Rx are subject to the deductible		
Plan maximums		
Calendar year deductible ⁴	\$3,000 (employee-only) / \$6,000 family (Employee and dependent)	
Out-of-pocket maximum (includes calendar year deductible)	\$4,000 (employee-only) / \$8,000 family (Employee and dependent)	
Lifetime maximum	No maximum	
Professional services		
Office visit copay (including specialist consultation) ⁵	50% (deductible not waived)	Not covered
Preventive care services ^{5,6}	Covered in full	Not covered
X-ray and laboratory procedures ^{5,7}	20%	40%
Hospital services⁷		
Inpatient hospital facility services (includes maternity)	20%	40%
Outpatient facility services (other than surgery)	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	40%
Emergency services		
Professional services	\$10 copay (deductible not waived)	
Emergency room facility (copayment waived if admitted)	\$100 copay + 20%	
Urgent care facility	\$50 copay + 20%	
Ambulance services (ground and air) ⁷	\$50 copay + 20%	\$50 copay + 40%
Behavioral services⁷		
Severe mental health (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Non-severe mental health (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Inpatient acute care detoxification	20%	40%
Other services		
Diabetic equipment	20%	40%
Acupuncture	20%	40%
	(12 visits per calendar year, PPO and OON combined)	
Chiropractic services	\$20 copay (deductible not waived; 12 visits per calendar year)	Not covered
Prescription drug coverage⁸	Subject to calendar year medical deductible	
Prescription drugs (up to a 30-day supply) ^{9,10}	\$10 / \$25 / \$50	50%
Specialty drugs (most self-injectables)	30%	Not covered

¹ Plan codes listed are in order of Non-Integrated and Integrated options.

² Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

³ Please refer to the Certificate of Insurance (COI) for out-of-network reimbursement methodology.

⁴ For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.

⁵ Preventive care services for women also includes: female contraceptive services, devices and supplies, female family planning, female preventive sterilizations, screening for gestational diabetes, domestic violence and HIV, breast feeding devices and supplies, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives and breastfeeding support.

⁶ Includes annual preventive physical, newborn and well child care, well woman exams, preventive lab and X-ray services.

⁷ Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admission, a \$250 deductible is required for each inpatient admission.

⁸ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

⁹ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.

¹⁰ Some plans will cover most female prescription contraceptives at \$0 cost share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost share and tier information.