



FROM |  Health Net®

Arizona Individual & Family Plans
Available through the Health Insurance Marketplace
Ambetter from Health Net, offered by
Health Net of Arizona, Inc. (Health Net)

Plan Overview

Ambetter Balanced Care 9 (2017)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility ^{1,4}
Deductible per calendar year	\$4,200 single / \$8,400 family
Coinsurance	20%
Out-of-pocket maximum Including all deductibles, copays and coinsurance	\$7,150 single / \$14,300 family
Maximum benefits in-network	Unlimited
Professional services	
Primary care physician (PCP)	\$30 copay/visit
Specialist physician	\$50 copay/visit
Preventive care ²	No charge
Prenatal care and postpartum care	\$30 copay/visit (PCP) / \$50 copay/visit (specialist)
Hearing exam / Hearing aid	
Hearing exam	\$50 copay/visit. One routine hearing exam/year.
Hearing aid	20% coinsurance after ded. One hearing aid per ear/per plan yr.
Laboratory services	
Physician's office or independent facility ³	\$20 copay/visit
Hospital	20% coinsurance after deductible
X-ray services	
Physician's office or independent facility ³	\$50 copay/visit
Hospital	20% coinsurance after deductible
Imaging and testing services (including but not limited to MRIs, MRAs, and PET / SPECT, ECT, and BEAM scans)	
Physician's office or independent facility ³	\$250 copay/visit
Hospital	20% coinsurance after deductible
Hospital services	
Inpatient hospital services (including physician, facility, surgery and labor/delivery)	20% coinsurance after deductible
Outpatient hospital / ambulatory surgical center services	20% coinsurance after deductible
Skilled nursing facility (100 days max/calendar year)	20% coinsurance after deductible

(continued)

Benefit description	Member(s) responsibility ^{1,2}
Emergency and urgent care services	
Emergency room services (copay waived if admitted)	\$400 copay/visit
Urgent care services	\$50 copay/visit
Ambulance services (medical emergencies only)	\$0
In-store health care clinic	\$30 copay/visit
Rehabilitative services	
Inpatient	20% coinsurance after deductible
Outpatient (max. 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	\$50 copay/visit
Habilitative services	
Inpatient	20% coinsurance after deductible
Outpatient (max. 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	\$50 copay/visit
Outpatient prescription drug services⁵	
Integrated prescription drug/medical deductible	\$4,200 single / \$8,400 family – waived for generic
Prescription drugs (up to a 30-day supply) – generic / preferred brand / non-preferred	\$20 / \$40 / \$70
Specialty pharmacy (most self-injectables)	50% coinsurance after deductible
Mail order program (90-day supply) – generic / preferred brand / non-preferred	\$60 / \$120 / \$210
Mental health / Substance abuse services	
Inpatient	20% coinsurance after deductible
Outpatient physician office visit	\$30 copay/visit
Outpatient services other than physician office visit	20% coinsurance
Durable medical equipment (DME)	20% coinsurance after deductible
Home health care services (Limited to part-time and intermittent care. Up to 60 days or longer when precertified. Limit in-network and out-of-network combined.)	\$0
Hospice care services	20% coinsurance after deductible
Chiropractic services Max. 20 visits/calendar year.	\$50 copay/visit
Allergy testing / treatment	
Allergy testing	\$50 copay/visit
Allergy serum	20% coinsurance after deductible
Allergy injection administrative charges	\$30 copay/visit (PCP) / \$50 copay/visit (specialist)
Pediatric vision services and medically necessary supplies	Covered for children up to age 19. \$0. One routine eye exam and one pair of eyeglasses (lenses and frames) or contact lenses per year. Exclusions and limitations apply.

For more information, visit Ambetter from Health Net's website at www.AmbetterHealthNet.com, or call Ambetter from Health Net at 1-888-926-5057.

¹Certain services require precertification from Health Net. Without precertification, the benefit is reduced by 50%.

²Preventive care services: This plan provides all coverage as required under the ACA, including evidence-based screening and counseling, routine immunizations, childhood preventive services, and preventive services for women, at no cost to members with an in-network provider. This coverage includes services such as preventive office visits, preventive lab and X-ray, Pap test and mammogram, prostate screening, immunizations, and colorectal cancer screening. You can find all the details on the government's website at www.healthcare.gov. Women's preventive services include screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; and human immunodeficiency virus (HIV) screening and counseling.

³These services also include FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity; breastfeeding support, supplies and counseling; and interpersonal and domestic violence screening and counseling.

⁴Some facilities are affiliated with a hospital. You may be charged a higher copayment or coinsurance for services at a hospital-affiliated facility. Contact the place of service for more information or the Customer Contact Center at the number on the back of your ID card.

⁵In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles.

⁶The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require precertification from Health Net. For a copy of the Essential Rx Drug List, go to Ambetter from Health Net's website. Refer to your *Schedule of Benefits* and coverage documents for complete information on prescription drugs. 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 Essential Rx Drug List for coverage, cost-share and tier information. Prescription drugs can be filled through mail order (up to a 90-day supply).