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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 Secure Care 4 (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]
Deductible per calendar year	$1,400 single / $2,800 family
Coinsurance	10%
Out-of-pocket maximum Including all deductibles, copays and coinsurance	$5,750 single / $11,500 family
Maximum benefits in-network	Unlimited
Professional services Primary care physician (PCP)	$10 copay/visit
Specialist physician	$30 copay/visit
Preventive care[2]	No charge
Prenatal care and postpartum care	$10 copay/visit (PCP)
Hearing exam / Hearing aid Hearing exam	$30 copay/visit. One routine hearing exam/year.
Hearing aid	10% coinsurance after ded. One hearing aid per ear/per plan year.
Laboratory services Physician's office or independent facility[3]	$0 copay/visit after deductible
Hospital	10% coinsurance after deductible
X-ray services Physician's office or independent facility[3]	$60 copay/visit after deductible
Hospital	10% 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 after deductible
Hospital	10% coinsurance after deductible
Hospital services Inpatient hospital services (including physician, facility, surgery and labor/delivery)	$375 copay/day, up to 3 days after deductible
Outpatient hospital / ambulatory surgical center services	10% coinsurance after deductible
Skilled nursing facility (100 days max./calendar year)	$375 copay/day, up to 3 days after deductible

(continued)

Benefit description	Member(s) responsibility[1]
Emergency and urgent care services Emergency room services (copay waived if admitted)	$150 copay after deductible
Urgent care services	$50 copay/visit
Ambulance services (medical emergencies only)	No charge
In-store health care clinic	$10 copay/visit
Rehabilitative services Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient (max. 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	$60 copay/visit after deductible
Habilitative services Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient (max. 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	$60 copay/visit after deductible
Outpatient prescription drug services[4] Brand-name calendar year deductible (per insured)	$1,400 single / $2,800 family – waived for generic and preferred brands
Prescription drugs (up to a 30-day supply) – generic / preferred brand / non-preferred	$15 / $50 / $70
Specialty pharmacy (most self-injectables)	50% coinsurance after deductible
Mail order program (90-day supply) –generic / preferred brand / non-preferred	$45 / $150 / $210
Mental health / Substance abuse services Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient physician office visit	$10 copay/visit
Outpatient services other than physician office visit	10% coinsurance after deductible
Durable medical equipment (DME)	10% 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.)	No charge
Hospice care services	$375 copay/day, up to 3 days after deductible
Chiropractic services Max. 20 visits/calendar year.	$30 copay/visit
Allergy testing / treatment Allergy testing	No charge
Allergy serum	20% coinsurance after deductible
Allergy injection administrative charges	$10 copay/visit (PCP) / $30 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.

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

[2]Preventive 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. These 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.

[3]Some 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.

[4]The 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 about 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).