

| | |
|---|---|
| Feature | Health Net Premier Network EPO - Pre-65 |
| Provider | Health Net Life Insurance Company, Inc. 1-800-695-2281 www.healthnet.com/ngc |
| | Cost Sharing |
| Annual Deductible | \$0 Individual; \$0 Family |
| Out-of-pocket maximum | \$0 Individual; \$0 Family |
| Lifetime coverage limit | \$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined |
| | Policies/Requirements |
| Need to file claims | No; except for covered urgent or emergency care received from an out-of-network provider |
| Domestic partner benefits | Yes |
| | Access |
| Ability to self-refer to OB/GYN | Yes |
| Ability to self-refer to specialists | Yes |
| Out-of-area dependent coverage | No |
| Out-of-area participant coverage | No |
| | Spending Account |
| HRA -- You only | Not applicable |
| HRA -- You and spouse | Not applicable |
| HRA -- You and child | Not applicable |
| HRA -- You and family | Not applicable |
| Eligible expenses for reimbursement | Not applicable |
| | Outpatient Services |
| Primary doctor office visit | \$20 copay; within selected medical group; \$40 copay outside selected medical group |
| Specialist doctor office visit | \$40 copay; specialist within medical group or Premier Network |
| | Preventive Care |
| Annual physical exam | \$20 copay PCP; \$40 copay specialist |
| Well-woman exam (includes pap) | \$20 copay PCP; \$40 copay specialist |
| Mammogram | 100% covered; age schedules apply; check with Plan for details |
| Pediatric exams | \$20 copay PCP; \$40 copay specialist |
| Immunizations (child) | Included with office visit copay |
| Colorectal screening | 100% covered |
| Cancer screenings | Included with office visit copay |
| Cardiovascular screenings | Included with office visit copay |
| Allergy tests and treatments | 100% covered; for serum and injection services; \$20 copay PCP/\$40 copay specialist for physician services |
| | Outpatient Care |
| Outpatient surgery | 100% covered; preauthorization required |
| Outpatient laboratory services | 100% covered; physician's office; \$20 copay at outpatient network laboratories |
| Outpatient physical therapy | \$20 copay; limited to 50 visits per benefit plan year |
| Outpatient X-ray | 100% covered; physician's office; \$20 copay at outpatient network laboratories |

| Feature | Health Net Premier Network EPO - Pre-65 |
|---|---|
| Outpatient occupational therapy | \$20 copay; limited to 50 visits per benefit plan year |
| Outpatient speech therapy | \$20 copay; limited to 50 visits per benefit plan year |
| Outpatient cardiac rehabilitation | \$20 copay; limited to Phase 1 and Phase 2 care |
| | Family Planning/Maternity Care |
| Office visit: pre/postnatal | \$20 copay initial visit only |
| In-hospital delivery services | \$200 copay; per admission; preauthorization required |
| Newborn nursery services | 100% covered; after inpatient hospital copay |
| Fertility services | 100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined including prescription drugs |
| In vitro fertilization | 100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined including prescription drugs |
| Artificial insemination | 100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined including prescription drugs |
| Female tubal ligation | 100% covered; outpatient hospital setting; \$20 copay PCP/\$40 copay specialist in office setting; \$200 copay inpatient hospital setting |
| Male vasectomy | 100% covered; outpatient hospital setting; \$20 copay PCP/\$40 copay specialist in office setting; \$200 copay inpatient hospital setting |
| | Hearing |
| Hearing evaluations | \$20 copay; PCP; \$40 copay specialist; limited to one exam per benefit plan year |
| Hearing aids | Limited to \$500 per ear per benefit plan year including exam, hearing aids (one hearing aid per ear every three years), and hearing aid repair |
| | Vision |
| Routine vision exams | \$20 copay; limited to PCP screening only, limited to one exam per benefit plan year |
| Regular lenses and frames | Not covered |
| Contact lenses | Not covered |
| | Dental |
| Dental implants | Not covered |
| Accidental injury to teeth | Coverage based on place of service; check with Plan for details |
| Surgical removal of tumors, cysts and impacted teeth | Coverage based on place of service; check with Plan for details; preauthorization required |
| | Inpatient Services |
| Hospital copay | \$200 copay per admission; preauthorization required |
| Hospital semi-private room | 100% covered after inpatient hospital copay |
| Inpatient lab and X-ray | 100% covered after inpatient hospital copay |
| Inpatient surgery | 100% covered after inpatient hospital copay |
| Inpatient physician and surgeon services | 100% covered after inpatient hospital copay |
| | Emergency Care |
| Emergency room (not followed by admission) | \$250 copay |
| Urgent care clinic visit | \$20 copay; limitations apply; check with Plan for details |
| Ambulance services | 100% covered |
| | Prescription Drug Coverage |
| Annual prescription deductible | Not applicable |
| Prescription drug website | Same as medical plan |
| Prescription drug member services | Same as medical plan |

| Feature | Health Net Premier Network EPO - Pre-65 |
|---|---|
| Prescription drug vendor | Same as medical plan |
| Annual Rx out-of-pocket maximum | \$1,500 Individual; \$3,000 Family |
| | Retail |
| Retail generic | \$5 copay or 10% coinsurance whichever is greater for formulary; \$40 copay or 10% coinsurance whichever is greater for nonformulary; 30 day supply |
| Retail formulary brand | \$20 copay or 10% coinsurance whichever is greater; 30 day supply |
| Retail nonformulary brand | \$40 copay or 10% coinsurance whichever is greater; 30 day supply |
| | Mail Order |
| Mail order generic | \$5 copay or 10% coinsurance whichever is greater for formulary; \$40 copay or 10% coinsurance whichever is greater for nonformulary; 90 day supply |
| Mail order formulary brand | \$20 copay or 10% coinsurance whichever is greater; 90 day supply |
| Mail order nonformulary brand | \$40 copay or 10% coinsurance whichever is greater; 90 day supply |
| | Other |
| Oral contraceptives | Retail and mail order available; applicable prescription drug copay applies |
| Fertility drugs | 100% covered after applicable copays; limited to \$25,000 per lifetime for all fertility services combined |
| Retail injectable drugs | 100% covered |
| | Mental Health |
| Mental Health: Combined with substance abuse | Yes |
| Mental Health: Outpatient coverage | \$20 copay; limited to 60 individual, group, or family visits per benefit plan year |
| Mental Health: Inpatient coverage | \$200 copay per admission; limited to 60 days per benefit plan year; preauthorization required |
| | Substance Abuse |
| Detox: Outpatient coverage | \$20 copay; limited to 60 individual, group or family visits per benefit plan year |
| Detox: Inpatient coverage | \$200 copay per admission; limited to two inpatient admissions per lifetime; preauthorization required |
| Rehab: Outpatient coverage | \$20 copay; limited to 60 individual, group, or family visits per benefit plan year |
| Rehab: Inpatient coverage | \$200 copay per admission; limited to 60 days per benefit plan year; limited to two inpatient admissions per lifetime; preauthorization required |
| | Alternative Care |
| Chiropractic | \$40 copay; limited to 40 visits per benefit plan year |
| Acupuncture | \$40 copay; limited to 20 visits per benefit plan year; acupressure not covered |
| | Care Management Programs |
| Heart disease care management | Yes |
| Hypertension care management | Yes |
| Diabetes care management | Yes |
| Asthma care management | Yes |
| Prenatal care management | Yes |
| Cancer care management | Yes |

| Feature | Health Net Premier Network EPO - Pre-65 |
|---|--|
| Smoking cessation program | Yes |
| Weight control program | Yes |
| | Other |
| Noncustodial home health care | 100% covered; limited to 120 visits per benefit plan year |
| Hospice care | 100% covered; bereavement counseling limited to \$500 for each occurrence; preauthorization required |
| Prescribed care in noncustodial skilled nursing facility | 100% covered; limited to 120 visits per benefit plan year; preauthorization required |
| Durable medical equipment | 100% covered; must be medically necessary |
| Prosthetic devices | 100% covered; must be medically necessary |