

## Plan Facts

|                         | Health Net EPO   |
|-------------------------|--|
| Web site                | <a href="http://healthnet.com/ngc">healthnet.com/ngc</a> |
| Member services         | 1-800-695-2281   |
| Find a network provider |  |
| Binding arbitration     | Yes  |

## Cost

|  | Health Net EPO  |
|--|---|
| <b>Health Reimbursement Arrangement--Account Information</b> |   |
| Eligible expenses for reimbursement                          | Not applicable  |
| <b>General Medical Expenses</b>                              |   |
| Deductible: Individual/Family                                | \$0 Individual; \$0 Family  |
| Primary doctor office visit                                  | \$20 copay  |
| Specialist office visit                                      | \$40 copay  |
| Out-of-pocket maximum: Individual/Family                     | \$0 Individual; \$0 Family  |
| Lifetime coverage limit                                      | \$2,000,000; for all Northrop Grumman-sponsored medical plan options; retiree and active combined   |
| <b>Inpatient Hospital Care</b>                               |   |
| Hospital copay   | \$200 copay per admission; preauthorization required  |
| Hospital semi-private room                                   | 100% covered after \$200 inpatient hospital copay; preauthorization required  |
| Inpatient lab and X-ray                                      | 100% covered; after \$200 inpatient hospital copay; preauthorization required   |
| Inpatient physician and surgeon services                     | 100% covered; after \$200 inpatient hospital copay; preauthorization required   |
| <b>Outpatient Care</b>                                       |   |
| Outpatient surgery   | 100% covered; preauthorization required   |
| Outpatient laboratory services                               | 100% covered; physician's office; \$20 copay at outpatient network laboratories; certain procedures require preauthorization; check with Plan for details |
| Outpatient X-ray   | 100% covered; physician's office; \$20 copay at outpatient network laboratories; certain procedures require preauthorization; check with Plan for details |
| Emergency room (not followed by admission)                   | \$250 copay   |
| Urgent care clinic visit                                     | \$20 copay; limitations apply; check with Plan for details  |
| <b>Prescription Drug Expenses</b>                            |   |
| Prescription drug vendor                                     | Same as medical plan  |
| Prescription drug Web site                                   | Same as medical plan  |
| Prescription drug member services                            | Same as medical plan  |

|                                |   |
|--------------------------------|---|
| Annual prescription deductible | Not applicable  |
| 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; chemically equivalent generics required; check with Plan for details   |
| Retail nonformulary brand      | \$40 copay or 10% coinsurance whichever is greater; 30 day supply; chemically equivalent generics required; check with Plan for details   |
| Mail order generic             | \$5 copay or 10% coinsurance whichever is greater formulary; \$40 copay or 10% coins whichever is greater nonformulary; 90 day supply; mail order required for maintenance medications; check with Plan |
| Mail order formulary brand     | \$20 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details                |
| Mail order nonformulary brand  | \$40 copay or 10% coinsurance whichever is greater; 90 day supply; chemically equivalent generics required; mail order required for maintenance medications; check with Plan for details                |
| Oral contraceptives            | Retail and mail order available; applicable prescription drug copay applies   |

## Coverage

| Health Net EPO                 |   |
|--------------------------------|---|
| <b>Adult Preventive Care</b>   |   |
| 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  |
| Cancer screenings              | Included with office visit copay  |
| Cardiovascular screenings      | Included with office visit copay  |
| <b>Family Planning</b>         |   |
| Fertility drugs                | 100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined |
| Fertility services             | 100% covered; after applicable copays; limited to \$12,500 per lifetime including prescription drugs        |

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| Artificial insemination                      | 100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined including prescription drugs                             |
| In vitro fertilization                       | 100% covered; after applicable copays; limited to \$12,500 per lifetime for all fertility services combined including prescription drugs                             |
| Male vasectomy                               | 100% covered; outpatient hospital setting; \$20 copay PCP/\$40 copay specialist in office setting; \$200 copay inpatient hospital setting; preauthorization required |
| <b>Maternity Care</b>                        |  |
| Office visit: Pre/postnatal                  | \$20 copay initial visit only  |
| In-hospital delivery services                | 100% covered; after \$200 inpatient hospital copay; notification requested   |
| Newborn nursery services                     | 100% covered; after \$200 inpatient hospital copay; notification requested   |
| Prenatal care management                     | Yes  |
| <b>Well-Baby/Well-Child Preventive Care</b>  |  |
| Well-child exams                             | \$20 copay; PCP; \$40 copay specialist   |
| Immunizations (child)                        | Included with office visit copay   |
| <b>Mental Health Care</b>                    |  |
| 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   |
| <b>Substance Abuse Care</b>                  |  |
| 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 60 days per benefit plan year; 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                     |
| <b>Dental Care</b>                           |  |
| Dental implants                              | Not covered  |
| Accidental injury to teeth                   | Coverage based on place of service; check with Plan for details  |

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| Surgical removal of tumors, cysts, and impacted teeth    | Coverage based on place of service; check with Plan for details; preauthorization required                     |
| <b>Vision Care</b>                                       |  |
| 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  |
| <b>Other Services</b>                                    |  |
| Ambulance services                                       | 100% covered; certain procedures require preauthorization; check with Plan for details                         |
| Allergy tests and treatments                             | 100% covered; for serum and injection services; \$20 copay PCP/\$40 copay specialist for physician services    |
| Durable medical equipment                                | 100% covered; must be medically necessary; certain items require preauthorization; check with Plan for details |
| <b>Hearing Care</b>                                      |  |
| Hearing evaluations                                      | \$20 copay; PCP; \$40 copay specialist; limited to one exam per benefit plan year                              |
| Hearing aids   | Limited to \$1,000 per benefit plan year; check with Plan for limitations                                      |
| <b>Medical Therapy</b>                                   |  |
| Acupuncture  | \$40 copay; limited to 20 visits per benefit plan year; acupressure not covered                                |
| Chiropractic   | \$40 copay; limited to 40 visits per benefit plan year   |
| Outpatient physical 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 occupational therapy                          | \$20 copay; limited to 50 visits per benefit plan year   |
| <b>Care at Alternate Sites</b>                           |  |
| Noncustodial home health care                            | 100% covered; limited to 120 visits per benefit plan year; preauthorization required                           |
| Prescribed care in noncustodial skilled nursing facility | 100% covered; limited to 120 days per benefit plan year; preauthorization required                             |
| Hospice care   | 100% covered; bereavement counseling limited to \$500 for each occurrence; preauthorization required           |

## Access

Health Net EPO

|                                  |    |
|----------------------------------|----|
| Out-of-area dependent coverage   | No |
| Out-of-area participant coverage | No |

## Ease of Use

|                                      | Health Net EPO   |
|--------------------------------------|--|
| Need to file claims                  | No; except for covered urgent or emergency care received from an out-of-network provider |
| Number of PCP changes allowed/year   | Not available  |
| Ability to self-refer to OB/GYN      | Yes  |
| Ability to self-refer to specialists | Yes  |

## Care Management: Education and Assistance

|                               | Health Net EPO |
|-------------------------------|----------------|
| Asthma care management        | Yes            |
| Cancer care management        | Yes            |
| Diabetes care management      | Yes            |
| Heart disease care management | Yes            |
| Hypertension care management  | Yes            |
| Smoking cessation program     | Yes            |
| Weight control program        | Yes            |