

Plan Overview

PPO Catastrophic \$0 / \$6,350 – 9LM

Benefits are subject to a deductible unless noted.

Benefit description	Insured person(s) responsibility	
	In-network ^{1,2}	Out-of-network ^{1,3}
Unlimited lifetime maximum.		
Plan maximums		
Calendar year deductible ⁴	\$6,350 single / \$12,700 family	\$12,700 single / \$25,400 family
Out-of-pocket maximum (includes calendar year deductible) ⁵	\$6,350 single / \$12,700 family	\$12,700 single / \$25,400 family
Professional services		
Office visit	Visits 1–3: 0% (ded waived)/ Visits 4+: 0% ⁶	50%
Specialist consultation	0%	50%
Preventive care services ⁷	0% (deductible waived)	Not covered
X-ray and laboratory procedures	0%	50%
Rehabilitation and habilitation therapy	0%	Not covered
Hospital services		
Inpatient hospital facility services (includes maternity)	0%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	0%	50%
Skilled nursing facility	0%	50%
Emergency services		
Emergency room (copayment waived if admitted)	0%	\$0
Urgent care	Visits 1–3: 0% (ded waived)/ Visits 4+: 0% ⁶	50%
Ambulance services (ground and air)	0%	\$0
Behavioral services		
Mental health / Chemical dependency rehabilitation (inpatient)	0%	50%
Mental health / Chemical dependency rehabilitation (outpatient)	Visits 1–3: 0% (ded waived)/ Visits 4+: 0% ⁶	50%
Home health care services (100 visits/year, in- and out-of-network combined)	0%	50%
Other services		
Durable medical equipment	0%	Not covered
Acupuncture (medically necessary)	0%	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage		
Subject to medical deductible		
Prescription drugs (up to a 30-day supply) ⁸	0%	Not covered
Specialty drugs (most self-injectables)	30%	Not covered
Pediatric dental ^{9,10} (Medical deductible applies)		
Diagnostic and preventive services	\$0	Not covered
Pediatric vision ⁹		
Eye exam	0% (deductible waived)	Not covered
Glasses	1 pair per year	Not covered

(continued)

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Policy for terms and conditions of coverage.

All applicants on the Catastrophic plan must be under the age of 30 or have a certificate showing exemption from the federal requirement to maintain minimum essential coverage.

¹ Certain services require prior certification from Health Net. Without prior certification, an additional \$250 is applied. Refer to the Policy for details.

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 Policy for out-of-network reimbursement methodology.

⁴ Any amount applied toward the calendar year deductible for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers. In addition, any amount applied toward the calendar year deductible for covered services and supplies received from an out-of-network provider will not apply toward the calendar year deductible for in-network providers.

⁵ Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.

⁶ Visits 1–3 (combined between office visits, Urgent Care, Prenatal and Postnatal visits, Outpatient Mental Health/Substance Abuse): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

⁷ Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women’s preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

⁸ 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 prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net’s website. Refer to the Policy 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 Policy and Health Net’s Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls.

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 Pediatric dental and vision are included on all plans.

¹⁰ The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family Policy for details.