

Plan Overview

Gold 80 PPO (BPY)

Benefit description	Insured person(s) responsibility	
	In-network ^{1,2}	Out-of-network ^{1,3}
Unlimited lifetime maximum.		
Plan maximums		
Calendar year deductible ⁴	\$0 single / \$0 family	\$0 single / \$0 family
Out-of-pocket maximum ⁵	\$6,250 single / \$12,500 family	\$12,500 single / \$25,000 family
Professional services		
Office visit	\$30	50%
Specialist consultation	\$50	50%
Preventive care services ⁶	\$0	Not covered
X-ray / Laboratory procedures	\$50 / \$30	50%
Rehabilitation and habilitation therapy	\$30	Not covered
Hospital services		
Inpatient hospital facility services (includes maternity)	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50%
Skilled nursing facility	20%	50%
Emergency services		
Emergency room (copayment waived if admitted)	\$250	\$250
Urgent care	\$60	50%
Ambulance services (ground and air)	\$250	\$250
Behavioral services		
Mental health / Chemical dependency rehabilitation (inpatient)	20%	50%
Mental health / Chemical dependency rehabilitation (outpatient office visit)	\$30	50%
Home health care services (100 visits/year, in- and out-of-network combined)	20%	50%
Other services		
Durable medical equipment	20%	Not covered
Acupuncture (medically necessary)	\$30	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage		
Brand-name calendar year deductible (per insured)	\$0 single / \$0 family	Not covered
Prescription drugs (up to a 30-day supply) ⁷	\$15 / \$50 / \$70	Not covered
Specialty drugs (including most self-injectables) ⁸	20%	Not covered
Pediatric vision⁹		
Routine eye exam	0%	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 Certificate of Insurance (COI) for terms and conditions of coverage.

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

²Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

³Please refer to the COI for out-of-network reimbursement methodology.

⁴Any amount applied toward the calendar year deductible (if applicable) 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.

⁵Copayments 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.

⁶Covered 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.

⁷The 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 COI 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 COI and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The COI is a legal, binding document. If the information in this brochure differs from the information in the COI, the COI 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.

⁸Specialty drugs include high cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

⁹Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.