

# Plan Overview

*Health Net Gold 80 HSP 0/35*

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

| <i>Benefit description</i>   | <i>Member(s) responsibility</i>  |
|--|----------------------------------|
| Unlimited lifetime maximum.  |                                  |
| <b>Plan maximums</b>   |                                  |
| Calendar year deductible   | \$0 single / \$0 family          |
| Out-of-pocket maximum  | \$6,200 single / \$12,400 family |
| <b>Professional services</b>   |                                  |
| Office visit copay   | \$35                             |
| Specialist visit   | \$55                             |
| Preventive care services <sup>1</sup>  | \$0                              |
| X-ray / Laboratory procedures  | \$50 / \$35                      |
| Rehabilitation and habilitation therapy  | \$35                             |
| <b>Outpatient services</b>   |                                  |
| Outpatient surgery (includes facility fee and physician/surgeon fees)  | 20%                              |
| <b>Hospital services</b>   |                                  |
| Inpatient hospital stay (includes maternity)   | 20%                              |
| Skilled nursing facility   | 20%                              |
| <b>Emergency services</b>  |                                  |
| Emergency room facility (waived if admitted)   | \$250                            |
| Emergency room professional fee (waived if admitted)   | 20%                              |
| Urgent care  | \$60                             |
| Ambulance services (ground and air)  | \$250                            |
| <b>Mental/Behavioral health/Substance use disorder services<sup>2</sup></b>  |                                  |
| Mental/Behavioral health/Substance use disorder (inpatient)  | 20%                              |
| Mental/Behavioral health/Substance use disorder office visit (outpatient)  | \$35                             |
| <b>Home health care services</b> (100 visits per calendar year)  | 20%                              |
| <b>Other services</b>  |                                  |
| Durable medical equipment  | 20%                              |
| Acupuncture (medically necessary)  | \$35                             |
| Chiropractic services  | Not covered                      |
| <b>Prescription drug coverage<sup>3,4</sup></b>  |                                  |
| Brand-name calendar year deductible  | \$0                              |
| Prescription drugs Tier 1 / Tier 2 / Tier 3 (up to a 30-day supply obtained through a participating pharmacy) <sup>3</sup> | \$15 / \$50 / \$70               |
| Tier 4 drugs <sup>5,6</sup>  | 20% (\$250 max)                  |
| <b>Pediatric dental<sup>7</sup></b>  |                                  |
| Diagnostic and preventive services   | \$0 (deductible waived)          |
| <b>Pediatric vision<sup>8</sup></b>  |                                  |
| Routine eye exam   | \$0 (deductible waived)          |
| Glasses (limitations apply)  | 1 pair per year                  |

*(continued)*

This plan is pending approval with the Department of Managed Health Care (DMHC).

<sup>1</sup>Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

<sup>2</sup>Benefits are administered by MHN Services, an affiliated behavioral health administrative services company which provides behavioral health services.

<sup>3</sup>The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

The brand-name prescription drug deductible, or medical deductible if applicable, must be paid before Health Net begins to pay for brand-name prescription drugs, including brand-name specialty drugs.

<sup>4</sup>Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

<sup>5</sup>Tier 4 drugs include: Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than \$600.

Specialty 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.

<sup>6</sup>Tier 4 drugs will have a copayment and coinsurance maximum of \$250 for an individual prescription of up to a 30-day supply.

<sup>7</sup>Pediatric dental HMO plans are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California (DBP). DBP is not affiliated with Health Net. See the plan's EOC for details.

<sup>8</sup>Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.