

# Plan Overview

## Health Net Bronze 60 PPO 6000/70

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.

Benefit description	Insured person(s) responsibility	
	In-network <sup>1,2</sup>	Out-of-network <sup>1,3</sup>
Unlimited lifetime maximum		
<b>Plan maximums</b>		
Calendar year deductible <sup>4</sup>	\$6,000 single / \$12,000 family	\$12,000 single / \$24,000 family
Out-of-pocket maximum (OOPM) <sup>5</sup>	\$6,500 single / \$13,000 family	\$13,000 single / \$26,000 family
<b>Professional services</b>		
Office visit	Visits 1–3: \$70 (deductible waived) / Visits 4+: \$70 <sup>6</sup>	50%
Specialist consultation	Visits 1–3: \$90 (deductible waived) / Visits 4+: \$90	50%
Preventive care services <sup>7</sup>	\$0 (deductible waived)	Not covered
X-ray <sup>8</sup> / Laboratory procedures	100% / \$40 (deductible waived)	100% / 50%
Rehabilitation and habilitation therapy	\$70 (deductible waived)	Not covered
<b>Hospital services</b>		
Inpatient hospital facility services (includes maternity) <sup>8</sup>	100%	100%
Outpatient surgery (hospital or outpatient surgery center charges only) <sup>8</sup>	100%	100%
Skilled nursing facility <sup>8</sup>	100%	100%
<b>Emergency services</b>		
Emergency room (waived if admitted) <sup>8</sup>	100%	100%
Emergency room professional fee (waived if admitted) <sup>8</sup>	100%	100%
Urgent care	Visits 1–3: \$120 (deductible waived) / Visits 4+: \$120 <sup>6</sup>	50%
Ambulance services <sup>8</sup> (ground and air)	100%	100%
<b>Behavioral services</b>		
Mental health / Chemical dependency rehabilitation (inpatient) <sup>8</sup>	100%	100%
Mental health / Chemical dependency rehabilitation (outpatient office visit)	Visits 1–3: \$70 (deductible waived) / Visits 4+: \$70 <sup>6</sup>	50%
<b>Home health care services</b> (100 visits/calendar year, in- and out-of-network combined) <sup>8</sup>	100%	100%
<b>Other services</b>		
Durable medical equipment <sup>8</sup>	100%	Not covered
Acupuncture (medically necessary)	Visits 1–3: \$70 (deductible waived) / Visits 4+: \$70 <sup>6</sup>	Not covered
Chiropractic services	Not covered	Not covered
<b>Prescription drug coverage</b>		
Prescription drug calendar year deductible (per insured)	\$500 single / \$1,000 family	Not covered
Prescription drugs Tier 1/ Tier 2 / Tier 3 (up to a 30-day supply) <sup>9,10</sup>	100% (\$500 max)	Not covered
Tier 4 (including most self-injectables) <sup>10,11</sup>	100% (\$500 max)	Not covered

(continued)

<i>Benefit description</i>	<i>Insured person(s) responsibility</i>	
	<b>In-network</b> <sup>1,2</sup>	<b>Out-of-network</b> <sup>1,3</sup>
<b>Pediatric dental</b> <sup>12</sup> Diagnostic and preventive services	\$0 (deductible waived)	\$0 (deductible waived)
<b>Pediatric vision</b> <sup>13</sup>		
Routine eye exam	0% (deductible waived)	Not covered
Glasses	1 pair per year	Not covered

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

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

<sup>3</sup>Please refer to the COI for out-of-network reimbursement methodology.

<sup>4</sup>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.

<sup>5</sup>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.

<sup>6</sup>Visits 1–3 (combined between office visits, urgent care, postnatal visits, outpatient mental health/substance abuse, and acupuncture): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

<sup>7</sup>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](http://www.healthcare.gov). The applicable cost-sharing for preventive care will apply to these services.

<sup>8</sup>After the medical deductible has been reached, the member is responsible for 100% of the eligible charges until their out-of-pocket maximum limit is met.

<sup>9</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 *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](http://www.healthnet.com).

<sup>10</sup>After the Pharmacy Deductible has been reached, the member will be responsible for 100% of the cost of all Tier 1, 2, 3, and 4 drugs up to a maximum payment of \$500 for each prescription of up to a 30-day supply, until the out-of-pocket maximum limit is met.

<sup>11</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>12</sup>Pediatric dental PPO plans are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services (DBP). DBP is not affiliated with Health Net. See the plan’s COI for details.

<sup>13</sup>Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

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