Health Net®

Plan Overview

Bronze 60 PPO (BG9)

Benefit description	*Insured person(s) responsibility*	
Unlimited lifetime maximum.	**In-network**[1,2]	**Out-of-network**[1,3]
Plan maximums Calendar year deductible[4]	$5,000 single / $10,000 family	$10,000 single / $20,000 family
Out-of-pocket maximum[5]	$6,250 single / $12,500 family	$12,500 single / $25,000 family
Professional services Office visit	Visits 1–3: $60 (deductible waived) / Visits 4+: $60[6]	50%
Specialist consultation	$70	50%
Preventive care services[7]	$0 (deductible waived)	Not covered
X-ray / Laboratory procedures	30%	50%
Rehabilitation and habilitation therapy	$60	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	30%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copayment waived if admitted)	$300	$300
Urgent care	Visits 1–3: $120 (deductible waived) / Visits 4+: $120[6]	50%
Ambulance services (ground and air)	$300	$300
Behavioral services Mental health / Chemical dependency rehabilitation (inpatient)	30%	50%
Mental health / Chemical dependency rehabilitation (outpatient office visit)	Visits 1–3: $60 (deductible waived) / Visits 4+: $60[6]	50%
Home health care services (100 visits/year, in- and out-of-network combined)	30%	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)	Visits 1–3: $60 (deductible waived) / Visits 4+: $60[6]	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage Prescription drug calendar year deductible (per insured)	Plan's calendar year deductible applies to all prescription drug tiers	Not covered
Prescription drugs (up to a 30-day supply)[8]	$15 / $50 / $75	Not covered
Specialty drugs (including most self-injectables)[9]	30%	Not covered
Pediatric dental[10] Diagnostic and preventive services	$0 (deductible waived)	$0 (deductible waived)
Pediatric vision[11] Routine eye exam	0% (deductible waived)	Not covered
Glasses	1 pair per year	Not covered

(continued)

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the COI 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 COI 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 and acupuncture): 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 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.

[9]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.

[10]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 Certificate of Insurance for details.

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