

# Plan Overview

PPO Platinum \$20 / \$0 – 9LP

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	\$0 single / \$0 family	\$0 single / \$0 family
Out-of-pocket maximum <sup>4</sup>	\$4,000 single / \$8,000 family	\$8,000 single / \$16,000 family
<b>Professional services</b>		
Office visit	\$20	50%
Specialist consultation	\$40	50%
Preventive care services <sup>5</sup>	\$0	Not covered
X-ray / Laboratory procedures	\$40 / \$20	50%
Rehabilitation and habilitation therapy	\$20	Not covered
<b>Hospital services</b>		
Inpatient hospital facility services (includes maternity)	10%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	50%
Skilled nursing facility	10%	50%
<b>Emergency services</b>		
Emergency room (copayment waived if admitted)	\$150	\$150
Urgent care	\$40	50%
Ambulance services (ground and air)	\$150	\$150
<b>Behavioral services</b>		
Mental health / Chemical dependency rehabilitation (inpatient)	10%	50%
Mental health / Chemical dependency rehabilitation (outpatient)	\$20	50%
<b>Home health care services</b> (100 visits/year, in- and out-of-network combined)	10%	50%
<b>Other services</b>		
Durable medical equipment	10%	Not covered
Acupuncture (medically necessary)	\$20	Not covered
Chiropractic services	Not covered	Not covered
<b>Prescription drug coverage</b>		
Brand-name calendar year deductible (per insured)	\$0	Not covered
Prescription drugs (up to a 30-day supply) <sup>6</sup>	\$5 / \$15 / \$25	Not covered
Specialty drugs (most self-injectables)	10%	Not covered
<b>Pediatric dental</b> <sup>7,8</sup> (\$60 deductible applies)		
Diagnostic and preventive services	\$0	Not covered
<b>Pediatric vision</b> <sup>7</sup>		
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 Policy for terms and conditions of coverage.**

<sup>1</sup> Certain services require prior certification from Health Net. Without prior certification, an additional \$250 is applied. Refer to the Policy 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 Policy for out-of-network reimbursement methodology.

<sup>4</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>5</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>6</sup> 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](http://www.healthnet.com).

<sup>7</sup> Pediatric dental and vision are included on all plans.

<sup>8</sup> 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.