

Plan Overview

Health Net Platinum 90 EPO

PureCare One EPO is offered in Contra Costa, Marin, Merced, Napa, Orange, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, and Tulare counties, and parts of Kern, Los Angeles, Riverside, and San Bernardino counties.

Benefit description	Member(s) responsibility ^{1,2}
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible	None
Out-of-pocket maximum ³ (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$4,000 single / \$8,000 family
Professional services	
Office visit copay	\$20
Specialist visit	\$40
Other practitioner office visit (including medically necessary acupuncture)	\$20
Preventive care services ⁴	\$0
X-ray and diagnostic imaging	\$40
Laboratory tests	\$20
Imaging (CT, PET scans, MRIs)	10%
Rehabilitation and habilitation therapy	\$20
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	10%
Hospital services	
Inpatient hospital facility (includes maternity)	10%
Skilled nursing care	10%
Emergency services	
Emergency room services (copay waived if admitted)	\$150 facility / 10% physician
Urgent care	\$40
Ambulance services (ground and air)	\$150
Mental/Behavioral Health/Substance use disorder services	
Mental/Behavioral health/Substance use disorder (inpatient)	10%
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: \$20 Other than office visit: \$0
Home health care services (100 visits per calendar year)	10%
Other services	
Durable medical equipment	10%
Hospice service	\$0
Self-injectables (other than insulin)	10% up to \$250/script
Prescription drug coverage⁵ (up to a 30-day supply obtained through a participating pharmacy)	
Tier I (most generics and low-cost preferred brands)	\$5
Tier II (non-preferred generics and preferred brands)	\$15
Tier III (non-preferred brands only)	\$25
Tier IV (Specialty drugs)	10% up to \$250/script
Pediatric dental^{6,7}	
Diagnostic and preventive services	\$0
Pediatric vision^{6,8}	
Routine eye exam	\$0
Glasses (limitations apply)	1 pair per year

(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.

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

² Please refer to the Policy for out-of-network reimbursement methodology.

³ 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.

⁴ 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.

⁵ 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.

⁶ Pediatric dental and vision are included on all plans.

⁷ The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

⁸ The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.