

BENEFITS AT A GLANCE

# Health Net PPO

## PLAN 2UA

Health Net PPO is a Preferred Provider Organization (PPO) plan. This means you choose your own doctors for all your health care needs and take advantage of significant cost savings when you use contracted PPO providers.

The doctors and hospitals you choose determine which services will be covered, as well as how much you will pay. For some services, certification of care is necessary to obtain full benefits.

You, the insured, are responsible for obtaining certification. Please obtain certification for non-emergency services at least five days prior to the service date. Call as soon as possible for emergency admission or surgery.

✍ **California** insureds, please call **1-800-774-4776**.

✍ Insureds who reside **outside of California**, call **1-877-838-2374**.

✍ For eligibility coverage, claims, or other information, please call Member Services at **1-800-861-7214**.

What the insured pays for services	PPO	Out-of-Network (OON)
<b>Professional services</b>		
Visits to physician, physician assistant or nurse practitioner at a contracting physician group	\$15 (deductible waived)	30% <sup>1</sup>
Preventive care		
Child (through age 16)	\$15 (deductible waived)	not covered
Adult (age 17 and older)	10%	not covered
Annual routine physical evaluations (age 17 and older; \$200 maximum per calendar year)	\$25 (deductible waived)	not covered
Vision and hearing examinations <sup>2</sup>	\$15 (deductible waived)	not covered
Specialist consultations	\$15 (deductible waived)	30% <sup>1</sup>
X-ray and laboratory procedures	10%	30% <sup>1</sup>
Allergy testing	\$15 (deductible waived)	30% <sup>1</sup>
Allergy serum	10%	30% <sup>1</sup>
Injections and injectable substances	\$15 (deductible waived)	30% <sup>1</sup>
Neuromuscular rehabilitation therapy	combined limit of 12 visits per calendar year (PPO/OON)	
Outpatient physical, speech, occupational, respiratory and cardiac therapy	\$25 maximum payable per visit (for OON only)	
	10%	30% <sup>1</sup>
<b>Care for conditions of pregnancy (professional services only)</b>		
Prenatal and postnatal care office visits	10%	30% <sup>1</sup>
Normal delivery, cesarean section; includes newborn inpatient professional care	10%	30% <sup>1</sup>
Elective abortions	10%	30% <sup>1</sup>
<b>Family planning (professional services only)</b>		
Infertility services	10%, \$500 deductible per lifetime required (\$2,000 lifetime maximum) <sup>3</sup>	30%, <sup>1</sup> \$500 deductible per lifetime required (\$2,000 lifetime maximum) <sup>3</sup>
Sterilization of females and males	10%	30% <sup>1</sup>

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<b>What the insured pays for services (continued)</b>	<b>PPO</b>	<b>Out-of-Network</b>
<b>Care for mental disorders and chemical dependency</b>		
Outpatient consultations (therapy, counseling in an outpatient mental health or chemical dependency rehabilitation care facility; \$25 maximum per visit)	combined limit of 20 visits per calendar year (PPO/OON) 10%	30% <sup>1</sup>
Inpatient care in mental health hospital or chemical dependency rehabilitation care facility (\$175 maximum allowable per day)	combined limit of 20 days per calendar year (PPO/OON) 10%	30% <sup>1</sup>
<b>Severe:</b> outpatient mental health consultation <sup>3</sup>	\$15	30%
Inpatient hospital care for mental disorders	10%	30%
Per-admission deductible	\$250	\$250
Physician mental health visit to hospital	10%	30%
<b>Other services</b>		
Chiropractic care (\$25 maximum per visit)	combined limit of 12 visits per calendar year (PPO/OON) \$15 copay (deductible waived)	30% <sup>1</sup>
Ambulance	10%, \$50 deductible	30% <sup>1</sup> \$50 deductible
Durable medical equipment	10% (\$1,000 annual maximum) <sup>3</sup>	30% (\$1,000 annual maximum) <sup>4</sup>
Prosthesis (replacing body parts)	10% (\$1,000 annual maximum) <sup>3</sup>	30% <sup>1</sup> (\$1,000 annual maximum) <sup>4</sup>
Blood, blood plasma, blood factors and blood derivatives	10%	10% <sup>1</sup>
Organ and bone marrow transplants	10%	not covered
Home health visits (\$110 maximum allowable per day)	combined limit of 100 visits per calendar year (PPO/OON) 10%	30% <sup>1</sup>
Hospice care	10% (\$5,000 lifetime maximum) <sup>3</sup>	30% <sup>1</sup> (\$5,000 lifetime maximum) <sup>4</sup>
<b>Hospital services</b>		
Inpatient services (\$250 deductible per admission)	10%	30% <sup>1</sup> (\$600 maximum allowable per day)
Outpatient surgery (\$250 deductible)	10%	30% <sup>1</sup>
<b>Skilled nursing facility</b>		
Inpatient services (\$250 deductible per admission)	combined limit of 100 days per calendar year (PPO/OON) 10%	30% <sup>1</sup> (\$250 maximum allowable per day)
<b>Emergency services</b>		
Emergency room services (\$100 deductible if not admitted to inpatient facility)	10%	10% <sup>1</sup>
Urgent care center services (\$100 deductible if not admitted to inpatient facility)	10%	10% <sup>1</sup>
<b>Out-of-pocket maximum</b>	\$3,000	\$5,000
<b>Lifetime maximum</b>	\$5,000,000 per insured	
<b>Calendar year deductible</b>	\$250 per insured/3 per family	

<sup>1</sup> Plus any amount in excess of covered expenses.

<sup>2</sup> Routine screenings only for children through age 16.

<sup>3</sup> The following conditions are considered severe mental illness: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorders, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children.

<sup>4</sup> Benefit maximum combined between PPO and Out-of-Network.

***This is only a summary of your benefits. It does not include all services, limitations or exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.***