

## Gold PPO 750/15

Benefit description	Member responsibility	
	In-network	Out-of-network
<b>Plan maximums</b>		
Calendar year deductible (individual / family) <sup>1</sup>	\$750 / \$1,500	\$2,250 / \$4,500
Out-of-pocket maximum (individual / family) <sup>2</sup>	\$8,200 / \$16,400	\$16,400 / \$32,800
<b>Professional services</b>		
PCP office visit	\$15 ded waived	50% ded applies
Specialist office visit	\$30 ded applies	50% ded applies
Preventive care services <sup>3</sup>	\$0 ded waived	50% ded applies
Telehealth services through Babylon <sup>4</sup>	\$0 ded waived	Not Covered
Rehabilitation therapy	\$15 ded waived	50% ded applies
X-ray procedures	\$25 ded applies	50% ded applies
Laboratory procedures	\$25 ded applies	50% ded applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	30% ded applies	50% ded applies
<b>Facility services</b>		
Outpatient surgery (ambulatory surgery center / hospital)	30% ded applies / 30% ded applies	50% ded applies / 50% ded applies
Inpatient hospital	30% ded applies	50% ded applies
Skilled nursing facility	30% ded applies	50% ded applies
<b>Emergency services</b>		
Urgent care services	\$30 ded applies	50% ded applies
Emergency room facility	\$250 ded applies	\$250 ded applies
Ambulance (ground and air)	\$250 ded applies	\$250 ded applies
<b>Mental health and substance use disorder services</b>		
Outpatient office visit	\$15 ded waived	50% ded applies
Outpatient other (includes partial hospitalization / day treatment / intensive outpatient programs)	30% ded applies	50% ded applies
Inpatient	30% ded applies	50% ded applies
<b>Other services</b>		
Durable medical equipment	30% ded applies	50% ded applies
Acupuncture services	\$15 ded waived	50% ded applies
Chiropractic services	\$25 ded waived (If Chiro Rider is Purchased)	50% ded applies (If Chiro Rider is Purchased)
<b>Prescription drug coverage</b>		
Prescription drug deductible (individual / family)	Combined Medical/Rx Deductible	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 <sup>5</sup>	\$15 ded waived / \$40 ded applies / \$70 ded applies	Not Covered
Tier 4 Specialty drugs <sup>5</sup>	30% ded applies	Not Covered
<b>Pediatric dental</b>		
Diagnostic and preventive services	\$0 ded waived	10% ded waived
<b>Pediatric vision</b>		
Routine eye exam	\$0 ded waived	Not Covered
Glasses	\$0 ded waived	Not Covered

## PPO Footnotes

- <sup>1</sup> Any amount applied toward the calendar year deductible (if applicable) 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>2</sup> Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and copayments or coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.
- <sup>3</sup> Preventive care services are covered for children and adults based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).
- <sup>4</sup> Listed cost share is for services provided through Babylon; For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.
- <sup>5</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 Pharmacy & 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.
- <sup>6</sup> Tier 4 drugs include when: the 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. Self-injectable drugs (other than insulin) are considered specialty drugs. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.