

Plan Overview

PPO P10-250-1-3500DX PD

YOU CAN USE THIS MATRIX TO HELP COMPARE COVERAGE BENEFITS. THIS MATRIX PRESENTS A HIGH-LEVEL SUMMARY. FOR A MORE DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS, REVIEW THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC).

The copayment amounts are the fees members will be charged for covered services received. Health Net and the contracted provider have agreed to the copayment amounts. Copayments can be a fixed-dollar amount or a percentage of Health Net's cost for the service or supply. You may also see percentage copayments referred to as coinsurance. Members pay fixed-dollar copayments when they receive the service. The provider will usually bill members for percentage copayments after the service is received. All services are subject to the deductible, unless noted otherwise.

Benefit description	Member responsibility	
Metal Level	Platinum	
Network	In-network	Out-of-network (MAA)
Deductible – single / family	\$250 / \$500	\$2,000 / \$4,000
Out-of-pocket maximum – single / family (includes deductible)	\$3,500 / \$7,000	\$7,000 / \$14,000
Preventive care Preventive health exams, colonoscopy (age 50+), routine immunizations, gynecological exam and pap, mammograms, PSA screening, tobacco cessation	\$0 / visit (deductible waived)	50% (deductible waived)
Office visits Physician - includes family practice, naturopath, pediatrics, internal medicine, general practice, obstetrics/gynecology Specialist physician - providers in specialties other than those listed above	Visits 1-3: \$5 (deductible waived) Visits 4+: \$10 (deductible waived) \$20 / visit (deductible waived)	50% 50%
Allergy and therapeutic injections	10%	50%
Telehealth services	\$0 / visit (deductible waived)	50%
Diagnostic services Diagnostic lab and X-ray, EKG, ultrasound Advanced diagnostic imaging, CT, MRI, PET, EEG, Holter monitor/ stress test	\$10 / visit (deductible waived) 10%	50% 50%
Maternity services Maternity delivery care (professional services only) Inpatient hospital services	10% 10%	50% 50%
Emergency and Medical Urgent Care Services Urgent Care physician services Outpatient emergency room services (no MAA out-of-network) Ambulance services - ground and air	\$20 / visit (deductible waived) 10% 10%	\$20 / visit (deductible waived) 10% 10%
Hospital services Inpatient hospital Inpatient rehabilitative services (physical, occupational, and speech therapy) - limit max 30 days per year Skilled nursing facility - limit max 60 days per year	10% 10% 10%	50% 50% 50%
Outpatient services Surgery, infusion, dialysis, chemotherapy, radiation therapy Surgery at hospital-based facility Surgery at ambulatory surgical center (ASC) Rehabilitative services - limit max 30 days per year	10% 10% 5% \$20 / visit (deductible waived)	50% 50% 50% 50%

Benefit description	Member responsibility	
Medical equipment and supplies		
Durable medical equipment, prosthetics, orthotics, diabetes supplies, oral sleep apnea appliance	10%	50%
Medical supplies, including allergy serum and injected substances	10%	50%
Home health and hospice		
Home health care	10%	50%
Hospice services	10%	50%
Mental health and substance use disorder services		
Physician services - office visit	Visits 1-3: \$5 (deductible waived) Visits 4+: \$10 (deductible waived)	50%
Urgent Care physician services	Visits 1-3: \$5 (deductible waived) Visits 4+: \$10 (deductible waived)	10%
Inpatient and residential services	10%	50%
Pharmacy		
Pharmacy Deductible	None	Not Covered
Generic/Preferred/Non-Preferred	\$10 / \$30 / \$60	Not Covered
Specialty drugs - including most self-injectable	50%	Not Covered
Mail order - 2 times copay for 90-day supply	\$20 / \$60 / \$120	Not Covered
Orally administered anticancer medication	10% deductible waived	Not Covered
Pediatric vision		
This plan covers routine vision services and supplies for children up to age 19. <i>You must utilize participating providers.</i>	• Routine eye exam limit: 1 per calendar year. • Provider-selected frames limit: 1 per calendar year.	• Routine eye exam limit: 1 per calendar year. • Provider-selected frames limit: 1 per calendar year.
Pediatric dental		
This plan may or may not be offered with pediatric dental services. If offered, pediatric dental services for covered members under age 19 are included as indicated here.	• Diagnostic and preventive services: 100% after \$100 deductible per member, per calendar year. • Basic, major services and medically necessary orthodontia: 50% after \$100 deductible per member, per calendar year.	• Diagnostic and preventive services: 100% after \$100 deductible per member, per calendar year. • Basic, major services and medically necessary orthodontia: 50% after \$100 deductible per member, per calendar year.

- The specified deductible must be met each calendar year (January 1 through December 31) before Health Net Health Plan of Oregon, Inc. pays any claims.
- The annual out-of-pocket maximum includes your annual deductible, copayments and coinsurance. After you reach the out-of-pocket maximum in a calendar year, we will pay your covered services during the rest of that calendar year at 100% of our contract rates for participating provider services and at 100% of the maximum allowable amount (MAA) for out-of-network (OON) services. You are still responsible for OON-billed charges that exceed MAA.
- For naturopathic care, call American Specialty Health, Inc. (ASH) at 1-800-678-9133.
- For mental health or chemical dependency services, call 800-977-8216.
- Telehealth services include coverage provided by Teladoc. Teladoc provides supplemental telehealth services in addition to the mandated telemedicine services for medical, mental disorders and chemical dependency conditions. Teladoc services are not intended to replace services from your physician. Teladoc consultation services do not cover specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential abuse.
- If a newborn patient requires admission to an intermediate or intensive care nursery, the deductible and coinsurance for these services will accumulate under the newborn's coverage, not under the mother's coverage.
- Certain services require prior authorization or must be performed by a specialty care provider.
- Prescription drug tiers are Tier 1: Generic; Tier 2: Brand Preferred; Tier 3: Non-Preferred; SP: Specialty. Retail Pharmacy – members may receive a 90-day fill at a retail pharmacy; one copayment/coinsurance applies per 30-day supply. MAC A applies. Essential Rx Drug List – A listing of preferred drugs and their corresponding benefit levels is shown on the Health Net Essential Rx Drug List (EDL). Visit Health Net at www.healthnetoregon.com to view Oregon Essential Rx Drug List.
- Certain drugs identified on the Essential Rx Drug List are classified as Specialty drugs under your plan. Specialty drugs are high-cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and have significantly higher cost than traditional pharmacy benefit drugs. Prior authorization is required for these medications.

This plan overview is intended to be used for marketing purposes only and presents general information. Please refer to your Benefit Schedule and Agreement for details, limitations, exclusions, and other terms and conditions of coverage.

Dental PPO insurance plans are underwritten by Health Net Health Plan of Oregon, Inc. and administered by Dental Benefit Providers, Inc. (DBP). Vision plans are underwritten by Health Net Health Plan of Oregon, Inc. and serviced by EyeMed Vision Care, LLC. Health Net Health Plan of Oregon, Inc., is a subsidiary of Health Net, LLC, and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.