

# Plan Overview

FULL NETWORK EOA

20/500/10% (\$3,500 / \$7,000)

| Benefit description                                                                                                                                                        | Member responsibility                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <b>Plan maximums</b>                                                                                                                                                       |                                                   |
| Out-of-pocket maximum (combined with Rx) (Individual / Family)                                                                                                             | HMO: \$3,500 / \$7,000<br>PPO: \$5,500 / \$11,000 |
| <b>Facility deductible</b>                                                                                                                                                 |                                                   |
| Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family) | \$500 / \$1,000                                   |
| <b>Professional services</b>                                                                                                                                               |                                                   |
| PCP Office visit <sup>1</sup>                                                                                                                                              | HMO: \$20 deductible waived<br>PPO: \$40          |
| Specialist Office visit <sup>1</sup>                                                                                                                                       | HMO: \$40 deductible waived<br>PPO: \$40          |
| Preventive care services <sup>1</sup>                                                                                                                                      | \$0 deductible waived                             |
| Telehealth services through the Select Telehealth Services Provider <sup>2</sup>                                                                                           | \$0 deductible waived                             |
| Rehabilitation therapy <sup>3</sup>                                                                                                                                        | HMO: \$20 deductible waived<br>PPO: \$40          |
| X-ray procedures <sup>1</sup>                                                                                                                                              | HMO: \$10 deductible waived<br>PPO: \$20          |
| Laboratory procedures <sup>1</sup>                                                                                                                                         | HMO: \$10 deductible waived<br>PPO: \$20          |
| Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)                                                                                                        | \$100 deductible waived                           |
| <b>Facility services</b>                                                                                                                                                   |                                                   |
| Outpatient services (hospital)                                                                                                                                             | 10% deductible applies                            |
| Outpatient services (ambulatory surgery center)                                                                                                                            | 5% deductible applies                             |
| Inpatient hospital                                                                                                                                                         | 10% deductible applies                            |
| Skilled nursing facility (100 day maximum)                                                                                                                                 | 10% deductible applies                            |
| <b>Emergency services</b>                                                                                                                                                  |                                                   |
| Urgent care services                                                                                                                                                       | \$20 deductible waived                            |
| Emergency room facility                                                                                                                                                    | \$150 deductible applies                          |
| Ambulance services (ground and air)                                                                                                                                        | \$150 deductible waived                           |
| <b>Mental health and substance use disorder services</b>                                                                                                                   |                                                   |
| Outpatient office visit                                                                                                                                                    | \$20 deductible waived                            |
| Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)                                                                            | \$0 deductible waived                             |
| Inpatient                                                                                                                                                                  | 10% deductible applies                            |
| <b>Other services</b>                                                                                                                                                      |                                                   |
| Durable medical equipment <sup>1</sup>                                                                                                                                     | \$0 deductible waived                             |
| Diabetic equipment                                                                                                                                                         | \$0 deductible waived                             |
| Acupuncture services <sup>4</sup>                                                                                                                                          | Rider available                                   |
| Chiropractic services <sup>4</sup>                                                                                                                                         | Rider available                                   |

<sup>1</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>2</sup> Listed cost share is for services provided through the Select Telehealth Services Provider; for all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.

<sup>3</sup> Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

<sup>4</sup> Chiropractic and/or Acupuncture rider coverage is included in all SmartCare HMO plans and is available as an optional benefit in all other HMO and EOA plans.

### *Health Net's Nondiscrimination Notice*

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

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