

## Plan Overview

FULL NETWORK EOA 40/30% (\$3,500 / \$7,000)

Plan maximums Out-of-pocket maximum (combined with Rx) (Individual / Family) Professional services, outpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family) Professional services, outpatient surgery, and ER facility benefits only. (Individual / Family) Professional services Professional services Specialist Office visit¹ HMC: \$40 PPC: \$60 PP	Benefit description	Member responsibility
Out-of-pocket maximum (combined with Rx) (Individual / Family)         HMC: \$3.500 / \$7.000 PPO: \$5.500 / \$11.000           Facility deductible Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family)         X/A // A           Professional services         HMC: \$40 PPO: \$60           Provisional services victs in the provisional services outpatient facility services outpatient services (Inspiral outpatient facility services outpatient services (Inspiral outpatient facility (100 day maximum)         Benote the services facility (100 day maximum)           Emergency services         40           Emergency services         \$40           Emergency services (Inspiral outpatient facility (100 day maximum)         \$200           Emergency services         \$40           Emergency services         \$40           Outpatient office visit         \$40           Outpatient office visit <td></td> <td> </td>		
Facility deductible Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family) Professional services PCP Office visit <sup>1</sup> Specialist Office visit <sup>1</sup> Prosentive care services <sup>1</sup> Specialist Office visit <sup>1</sup> Proventive care services <sup>1</sup> Specialist office visit <sup>1</sup> Provisional services fundant in the select Telehealth Services Provider <sup>2</sup> Specialist office visit <sup>1</sup> HMO: 540 Pro: 560 Pro: 560 Proventive care services <sup>1</sup> Specialist or therapy <sup>3</sup> HMO: 540 Pro: 560 Rehabilitation therapy <sup>3</sup> HMO: 540 Pro: 550 Pro: 550 Pro: 550 Rehabilitation therapy <sup>3</sup> HMO: 540 Pro: 530 Rehabilitation therapy <sup>3</sup> HMO: 520 Pro: 530 Laboratory procedures <sup>1</sup> HMO: 520 Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Specialist services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 530 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 540 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 540 Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI) Pro: 540 Complex radiology services (includes CT, SPECT, PET, MUGA,		HMO: \$3,500 / \$7,000
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Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family)         N/A / N/A           Professional services         HMO: \$40 PPO: \$60           Specialist Office visit¹         HMO: \$50 PPO: \$60           Preventive care services¹         \$0           Telehealth services through the Select Telehealth Services Provider²         \$0           Rehabilitation therapy²         HMO: \$40 PPO: \$60           **Aray procedures¹         HMO: \$40 PPO: \$60           Laboratory procedures¹         HMO: \$40 PPO: \$60           Laboratory procedures¹         HMO: \$40 PPO: \$40           Complex radiology services (includes CT, \$PECT, PET, MUGA, and MRI)         \$100           Complex radiology services (includes CT, \$PECT, PET, MUGA, and MRI)         \$100           Facility services         \$100           Outpatient services (includes CT, \$PECT, PET, MUGA, and MRI)         \$100           Inpatient hospital         30%           Skilled nursing facility (100 day maximum)         20%           Days 1-10: \$50 per day           Emergency services         \$40           Emergency room facility         \$40           Mental health and substance use disorder services         \$40           Outpatient office visit         \$40	Facility deductible	197
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Specialist Office visit¹         HMO: \$60 PPO: \$60           Preventive care services¹         \$0           Telehealth services through the Select Telehealth Services Provider²         \$0           Rehabilitation therapy³         HMO: \$40 PPO: \$60           X-ray procedures¹         HMO: \$20 PPO: \$30           Laboratory procedures¹         HMO: \$20 PPO: \$30           Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)         \$100           Facility services           Outpatient services (hospital)         30%           Outpatient services (hospital)         30%           Inpatient hospital         30%           Skilled nursing facility (100 day maximum)         Days 1-10: \$0           Days 11-10: \$25 per day         \$40           Emergency services         \$40           Urgent care services (ground and air)         \$40           Mental health and substance use disorder services         \$40           Outpatient other (includes partial hospitalization/day treatment/intensive outpatient orgerms)         \$40           Outpatient other (includes partial hospitalization/day treatment/intensive outpatient orgerms)         \$0           Inpatient         30%           Other services         \$0           Durable medical equipment¹         \$0           Labet	PCP Office visit <sup>1</sup>	HMO: \$40
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outpatient programs)     30%       Inpatient     30%       Other services     \$0       Durable medical equipment <sup>1</sup> \$0       Diabetic equipment     \$0       Acupuncture services <sup>4</sup> Rider available		·
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Acupuncture services <sup>4</sup> Rider available		•
The particular services		· ·
	Chiropractic services <sup>4</sup>	

<sup>&</sup>lt;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>&</sup>lt;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>&</sup>lt;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.

<u>Health Net's Nondiscrimination Notice</u>
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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