

# Plan Overview

## PPO HIGH DEDUCTIBLE 3300-3-6750ES 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	
<b>Metal Level</b>	Silver	
<b>Network</b>	<b>In-network</b>	<b>Out-of-network (MAA)</b>
<b>Deductible – single / family</b>	\$3,300 / \$6,600	\$7,000 / \$14,000
<b>Out-of-pocket maximum – single / family (includes deductible)</b>	\$6,750 / \$13,500	\$13,500 / \$27,000
<b>Preventive care</b> Preventive health exams, colonoscopy (age 50+), routine immunizations, gynecological exam and pap, mammograms, PSA screening, tobacco cessation	\$0 / visit (deductible waived)	50% (deductible waived)
<b>Office visits</b> Physician - includes family practice, naturopath, pediatrics, internal medicine, general practice, obstetrics/gynecology	30%	50%
Specialist physician - providers in specialties other than those listed above	30%	50%
Allergy and therapeutic injections	30%	50%
<b>Telehealth services</b>	0%	50%
<b>Diagnostic services</b> Diagnostic lab and X-ray, EKG, ultrasound	30%	50%
Advanced diagnostic imaging, CT, MRI, PET, EEG, Holter monitor/ stress test	30%	50%
<b>Maternity services</b> Maternity delivery care (professional services only)	30%	50%
Inpatient hospital services	30%	50%
<b>Emergency and Medical Urgent Care Services</b> Urgent Care physician services	30%	30%
Outpatient emergency room services (no MAA out-of-network)	30%	30%
Ambulance services - ground and air	30%	30%
<b>Hospital services</b> Inpatient hospital	30%	50%
Inpatient rehabilitative services (physical, occupational, and speech therapy) - limit max 30 days per year	30%	50%
Skilled nursing facility - limit max 60 days per year	30%	50%
<b>Outpatient services</b> Surgery, infusion, dialysis, chemotherapy, radiation therapy	30%	50%
Surgery at hospital-based facility	30%	50%
Surgery at ambulatory surgical center (ASC)	20%	50%

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

- 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](http://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 Centene Vision Services. Health Net Health Plan of Oregon, Inc., and Centene Vision Services are subsidiaries 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.