

Gold PPO 350/25

Benefit description	Member responsibility	
	In-network	Out-of-network
Plan maximums		
Calendar year deductible (individual / family) ¹	\$350 / \$700	\$2,000 / \$4,000
Out-of-pocket maximum (individual / family) ²	\$7,800 / \$15,600	\$15,600 / \$31,200
Professional services		
PCP office visit	\$25 ded waived	50% ded applies
Specialist office visit	\$50 ded waived	50% ded applies
Preventive care services ³	\$0 ded waived	50% ded applies
Telehealth services through Health Net's Select Telehealth Service Provider ⁴	\$0 ded waived	Not Covered
Rehabilitation therapy	\$25 ded waived	50% ded applies
X-ray procedures	\$65 ded waived	50% ded applies
Laboratory procedures	\$25 ded waived	50% ded applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	20% ded waived	50% ded applies
Facility services		
Outpatient surgery (ambulatory surgery center / hospital)	20% ded waived / 20% ded waived	50% ded applies / 50% ded applies
Inpatient hospital	20% ded applies	50% ded applies
Skilled nursing facility	20% ded applies	50% ded applies
Emergency services		
Urgent care services	\$25 ded waived	50% ded applies
Emergency room facility	20% ded applies	20% ded applies
Ambulance (ground and air)	20% ded applies	20% ded applies
Mental health and substance use disorder services		
Outpatient office visit	\$25 ded waived	50% ded applies
Outpatient other (includes partial hospitalization / day treatment / intensive outpatient programs)	20% ded waived (up to \$25)	50% ded applies
Inpatient	20% ded applies	50% ded applies
Other services		
Durable medical equipment	20% ded waived	50% ded applies
Acupuncture services	\$25 ded waived	50% ded applies
Chiropractic services	\$15 ded waived (If Chiro Rider is Purchased)	50% ded applies (If Chiro Rider is Purchased)
Prescription drug coverage		
Prescription drug deductible (individual / family)	\$0 / \$0	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁵	\$15 / \$50 / \$80	Not Covered
Tier 4 Specialty drugs ⁵	20%	Not Covered
Pediatric dental		
Diagnostic and preventive services	\$0 ded waived	10% ded waived
Pediatric vision		
Routine eye exam	\$0 ded waived	Not Covered
Glasses	\$0 ded waived	Not Covered