

Plan Overview

10/250/20% (\$4,000 / \$8,000)

PPO

Benefit description	Member responsibility	
	IN-NETWORK	OUT-OF-NETWORK ¹
Plan maximums		
Out-of-pocket maximum (combined with Rx) (Individual / Family)	\$4,000 / \$8,000	\$8,000 / \$16,000
Calendar year deductible (Individual / Family)	\$250 / \$750	\$500 / \$1,500
Coinsurance	20% deductible applies	40% deductible applies
Professional services		
PCP office visit ²	\$10 deductible waived	40% deductible applies
Specialist office visit ²	\$30 deductible waived	40% deductible applies
Preventive care services ²	\$0 deductible waived	40% deductible applies
Telehealth services through the Select Telehealth Services Provider ³	\$0 deductible waived	Not Covered
Rehabilitation therapy ⁴	20% deductible applies	40% deductible applies
X-ray procedures ²	20% deductible applies	40% deductible applies
Laboratory procedures ²	20% deductible applies	40% deductible applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	20% deductible applies	40% deductible applies
Facility services		
Outpatient surgery (hospital)	20% deductible applies	40% deductible applies
Outpatient surgery (ambulatory surgery center)	10% deductible applies	40% deductible applies
Inpatient hospital	20% deductible applies	40% deductible applies
Skilled nursing facility (100 day maximum)	20% deductible applies	40% deductible applies
Emergency services		
Urgent care services	\$10 deductible waived	40% deductible applies
Emergency room facility	\$100 + 20% deductible applies	\$100 + 20% deductible applies
Ambulance services (ground and air)	\$100 + 20% deductible applies	\$100 + 20% deductible applies
Mental health and substance use disorder services		
Outpatient office visit	\$10 deductible waived	40% deductible applies
Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)	20% deductible applies	40% deductible applies
Inpatient	20% deductible applies	40% deductible applies
Other services		
Durable medical equipment ²	20% deductible applies	40% deductible applies
Diabetic equipment	20% deductible applies	40% deductible applies
Acupuncture services	Rider available	Rider available
Chiropractic services	Rider available	Rider available

¹Out-of-network reimbursement based on maximum allowable amount. The covered person is responsible for charges in excess of maximum allowable charges in addition to the coinsurance shown.

²Preventive 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).

³Listed 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.

⁴Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

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 Certificate of Insurance for all terms and conditions of coverage.

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