

Plan Overview

0/1000/20% (\$5,000 / \$10,000)

PPO

Benefit description	Member responsibility	
	IN-NETWORK	OUT-OF-NETWORK ¹
Plan maximums		
Out-of-pocket maximum (combined with Rx) (Individual / Family)	\$5,000 / \$10,000	\$10,000 / \$20,000
Calendar year deductible (Individual / Family)	\$1,000 / \$3,000	\$2,000 / \$6,000
Coinsurance	20% deductible applies	40% deductible applies
Professional services		
PCP office visit ²	\$0 deductible waived	40% deductible applies
Specialist office visit ²	\$20 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	\$0 deductible waived	40% deductible applies
Laboratory procedures ²	\$0 deductible waived	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	\$0 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	\$0 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.

Health Net of California, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All rights reserved.