Large Group

Plan Overview

20/500/10% ($3,000 / $6,000)
PPO

Benefit description	Member responsibility	
	IN-NETWORK	OUT-OF-NETWORK[1]
Plan maximums Out-of-pocket maximum (combined with Rx) (Individual / Family)	$3,000 / $6,000	$6,000 / $12,000
Calendar year deductible (Individual / Family)	$500 / $1,500	$1,000 / $3,000
Coinsurance	10% deductible applies	30% deductible applies
Professional services PCP office visit[2]	$20 deductible waived	30% deductible applies
Specialist office visit[2]	$40 deductible waived	30% deductible applies
Preventive care services[2]	$0 deductible waived	30% deductible applies
Telehealth services through the Select Telehealth Services Provider[3]	$0 deductible waived	Not Covered
Rehabilitation therapy[4]	10% deductible applies	30% deductible applies
X-ray procedures[2]	10% deductible applies	30% deductible applies
Laboratory procedures[2]	10% deductible applies	30% deductible applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	10% deductible applies	30% deductible applies
Facility services Outpatient surgery (hospital)	10% deductible applies	30% deductible applies
Outpatient surgery (ambulatory surgery center)	5% deductible applies	30% deductible applies
Inpatient hospital	10% deductible applies	30% deductible applies
Skilled nursing facility (100 day maximum)	10% deductible applies	30% deductible applies
Emergency services Urgent care services	$20 deductible waived	30% deductible applies
Emergency room facility	$100 + 10% deductible applies	$100 + 10% deductible applies
Ambulance services (ground and air)	$100 + 10% deductible applies	$100 + 10% deductible applies
Mental health and substance use disorder services Outpatient office visit	$20 deductible waived	30% deductible applies
Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)	10% deductible applies	30% deductible applies
Inpatient	10% deductible applies	30% deductible applies
Other services Durable medical equipment[2]	10% deductible applies	30% deductible applies
Diabetic equipment	10% deductible applies	30% deductible applies
Acupuncture services	Rider available	Rider available
Chiropractic services	Rider available	Rider available

[1]Out-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.
[2]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).
[3]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.
[4]Rehabilitation 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.

1/2025