

Silver HDHP PPO 1600/50%

Benefit description	Member responsibility	
	In-network	Out-of-network
Plan maximums		
Calendar year deductible (individual / family) ¹	\$1,600 / \$3,200	\$3,200 / \$6,400
Out-of-pocket maximum (individual / family) ²	\$7,500 / \$15,000	\$15,000 / \$30,000
Professional services		
PCP office visit	50% ded applies	50% ded applies
Specialist office visit	50% ded applies	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 applies	Not Covered
Rehabilitation therapy	50% ded applies	50% ded applies
X-ray procedures	50% ded applies	50% ded applies
Laboratory procedures	50% ded applies	50% ded applies
Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)	50% ded applies	50% ded applies
Facility services		
Outpatient surgery (ambulatory surgery center / hospital)	50% ded applies / 50% ded applies	50% ded applies / 50% ded applies
Inpatient hospital	50% ded applies	50% ded applies
Skilled nursing facility	50% ded applies	50% ded applies
Emergency services		
Urgent care services	50% ded applies	50% ded applies
Emergency room facility	50% ded applies	50% ded applies
Ambulance (ground and air)	50% ded applies	50% ded applies
Mental health and substance use disorder services		
Outpatient office visit	50% ded applies	50% ded applies
Outpatient other (includes partial hospitalization / day treatment / intensive outpatient programs)	50% ded applies	50% ded applies
Inpatient	50% ded applies	50% ded applies
Other services		
Durable medical equipment	50% ded applies	50% ded applies
Acupuncture services	\$15 ded applies	50% ded applies
Chiropractic services	\$15 ded applies (If Chiro Rider is Purchased)	50% ded applies (If Chiro Rider is Purchased)
Prescription drug coverage		
Prescription drug deductible (individual / family)	Combined Medical/Rx Deductible	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁵	\$20 ded applies / \$70 ded applies / \$100 ded applies	Not Covered
Tier 4 Specialty drugs ⁵	50% ded applies	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