Health Net®

Health Net of California, Inc. and
Health Net Life Insurance Company (Health Net)

SMALL BUSINESS GROUP

Small Group Solutions 2020

YOUR GUIDE TO HEALTH NET PLANS FOR 1–100 EMPLOYEES

Effective January 1, 2020

BROKER COMMUNICATIONS

Coverage for every stage of life™

Coverage for Every Stage of Life™

We believe every person deserves a safety net for their health – regardless of age, income, employment status, or current state of health.

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We look forward to helping you offer the **benefits** your employees **value** at a cost that's good for business.

Satisfaction Starts Here

SMALL GROUP SOLUTIONS FOR 2020

Move your business forward – by giving your employees affordable, flexible HMO and PPO options! We offer an array of robust small business-focused solutions. It's easy to select the right plan and network. And with round-the-clock care options, concierge-style service, wellness programs, and other extras, our plans offer value beyond benefits. The net result is satisfaction – for you and your employees.

Choose from a wide range of cost and coverage options

We strive to offer right-size plans that suit both your employees and your balance sheet. Our HMO, HSP and PPO options, each matched with a network of select local care providers, offer favorable rates across the portfolio.

Mix-and-match plans and networks

Employees pick their favorite plan design, then pair it with any of the networks we offer in their region. The plan design stays the same. The process is quick and easy – and we're here to help every step of the way.

HMO

Step 1: Pick your plan design.

- PLATINUM $10
- PLATINUM $20
- PLATINUM $30
- GOLD $30
- GOLD $35
- GOLD $40
- GOLD $50
- SILVER $50

Step 2: Pair your plan with any of the networks we offer in your location.

- FULL NETWORK
- WHOLECARE
- SMARTCARE
- SALUD HMO Y MÁS

There is a mix and match option for L.A. employers who prefer PPO.

PPO

Step 1: Pick your plan design.

- PLATINUM 250/15
- GOLD 0/30
- GOLD 500/20
- GOLD 1000/30
- GOLD VALUE
- SILVER 2250/55
- SILVER VALUE
- SILVER HDHP
- BRONZE HDHP

Step 2: Pair your plan with the network that fits and is available in the group's location.

- FULL PPO NETWORK
- ENHANCEDCARE PPO NETWORK

Ensure around-the-clock access to care

Our members can always get the care they need, when they need it. All of our plans offer a 24/7 toll-free nurse advice line and access to **MinuteClinic** walk-in clinics across the country. All of our HMO, HSP and PPO plans offer virtual doctor visits via **Teladoc** and also include access to Heal in-home doctor visits for added convenience![1]

Options for extra coverage

Health Net offers add-on dental, vision and life insurance/AD&D plans, and homeopathic health care options, such as chiropractic. With options like these, it's easy for members to build a health plan that suits their unique needs.

Ask our at-your-service team

Our concierge-style customer care team is ready to help. Have a question or concern? We've made it our mission to respond quickly by phone or email with the help you need.

Stay connected on the go

Members can log in to healthnet.com or use our mobile app to access benefit information, wellness programs, identification (ID) cards, and more.

[1]Heal in-home doctor visits on HMO and HSP plans are limited to urgent care services only. PPO plans cover Heal in-home doctor visits related to urgent care, preventive and primary care.

Value Beyond Benefits

We want your employees to get the most from their health plans. That's why we offer programs to support their health and wellness. Resources like Decision Power®, Active & Fit Direct™, myStrength, and wellness coaching can help members lose weight, quit smoking and manage stress – so that members can live healthy, productive lives:

- **Decision Power** – Whether the focus is on staying fit, making smarter health care decisions or facing a serious diagnosis, Decision Power brings together information, resources and personal support members need to take charge of their health.
- **Active&Fit Direct** – Members who enroll with Active&Fit Direct can choose from 9000+ participating fitness centers nationwide for just $25 a month (plus a one-time $25 enrollment fee and applicable taxes).
- **myStrength** – This confidential online resource features self-help tools to help members take care of their mind and body. Using a variety of mood-improving resources, step-by-step eLearning modules and interactive tools, myStrength helps members to become – and stay – mentally and physically healthy.
- **Wellness coaching** – Our online health promotion programs use "virtual coaching," personalized weekly tasks and goal-setting tips on a number of topics, such as healthy eating, weight loss, exercise, and ending tobacco use.

Enhanced Choice Packages

TWO WAYS TO OFFER MULTIPLE PLANS

Health Net invites you to be choosy!

Health Net's package pairings give small business groups the option to offer multiple plans to their employees. Your clients have their choice of Enhanced Choice A or Enhanced Choice B. Then they can offer any number or combination of plans within the chosen package and available in their region.

ENHANCED CHOICE PARTICIPATION REQUIREMENTS

Eligible employees + Employee participation minimum:

1–5 + 66%

6–100 + 50%

+

Employer pays:

Minimum of 50% of base plan monthly

or

Minimum of $100 per employee toward the employee-only rate

=

Employees get:

Access to Health Net's

Enhanced Choice portfolio

TWO PACKAGES THAT OFFER MULTIPLE PLANS

Enhanced Choice A

- Full Network HMO
- WholeCare HMO
- SmartCare HMO
- Salud HMO y Más
- CommunityCare HMO
- PureCare HSP
- Full Network PPO

Enhanced Choice B

- Full Network HMO
- WholeCare HMO
- SmartCare HMO
- Salud HMO y Más
- CommunityCare HMO
- PureCare HSP
- EnhancedCare PPO
- Full Network PPO Bronze plans

Medical Portfolio At-a-Glance

Plan name	Member(s) responsibility									
	DEDUCTIBLE (SINGLE / FAMILY)	OUT-OF-POCKET MAXIMUM (SINGLE / FAMILY)	OFFICE / SPECIALIST VISIT	LAB / X-RAYS	OUTPATIENT SURGERY (ASC / HOSPITAL)	INPATIENT HOSPITAL	EMERGENCY ROOM FACILITY	URGENT CARE	PHARMACY	
									RX DED. (SINGLE / FAMILY)	RX DRUG TIER 1 / 2 / 3 / 4
PLAN DESIGNS OFFERED ON FULL NETWORK HMO, WHOLECARE HMO, SMARTCARE HMO, AND SALUD HMO Y MÁS[2] AVAILABLE THROUGH HEALTH NET OF CALIFORNIA, INC.										
Platinum $10	$0	$2,500 / $5,000	$10 / $30	$10 / $10	$40 / $100	$250 per day (3-day max copay per admission)	$100	$30	$0	$5 / $30 / $50 / 30%[3]
Platinum $20	$0	$3,000 / $6,000	$20 / $40	$10 / $10	$200 / $500	$350 per day (3-day max copay per admission)	$150	$40	$0	$5 / $30 / $50 / 30%[3]
Platinum $30	$0	$2,250 / $4,500	$30 / $50	$20 / $50	$150 / $150	$500 per day (4-day max copay per admission)	$250	$30	$0	$5 / $20 / $30 / 30%[3]
Gold $30	$0	$6,000 / $12,000	$30 / $50	$40 / $40	$360 / $900	$750 per day (3-day max copay per admission)	$300	$50	$0	$15 / $50 / $70 / 30%[3]
Gold $35	$0	$6,000 / $12,000	$35 / $55	$40 / $50	$480 / $1,200	$750 per day (3-day max copay per admission)	$300	$55	$0	$15 / $50 / $70 / 30%[3]
Gold $40	$0	$6,500 / $13,000	$40 / $60	$40 / $40	$440 / $1,100	$750 per day (3-day max copay per admission)	$300	$60	$0	$15 / $50 / $70 / 30%[3]
Gold $50	$0	$7,000 / $14,000	$50 / $70	$40 / $50	$480 / $1,200	$750 per day (4-day max copay per admission)	$300	$70	$200 / $400	$15[4] / $50 / $70 / 40%[3]
Silver $50	$0	$7,800 / $15,600	$50 / $70	$40 / $50	40% / 50%	50%	50%	$70	$500 / $1,000	$20[4] / 50%[3] / 50%[3] / 50%[3]
PLAN DESIGNS OFFERED ON COMMUNITYCARE HMO[2] AVAILABLE THROUGH HEALTH NET OF CALIFORNIA, INC.										
Silver $50	$1,750 / $3,500	$7,800 / $15,600	$50[4] / $70[4]	$40 / $50	30% / 40%	40%	40%	$70[4]	$250 / $500	$15[4] / 40%[3] / 40%[3] / 40%[3]
CommunityCare Bronze 60 HMO 6300/65 + Child Dental	$6,300 / $12,600	$7,800 / $15,600	$65[6] / $95[6]	$40[4] / 40%	40% / 40%	40%	40%	$65[6]	$500 / $1,000	$18 / 40%[5] / 40%[5] / 40%[5]

(continued)

Plan name	Member(s) responsibility										
	DEDUCTIBLE (SINGLE / FAMILY)	OUT-OF-POCKET MAXIMUM (SINGLE / FAMILY)	COINSURANCE	OFFICE / SPECIALIST VISIT	LAB / X-RAYS	OUTPATIENT SURGERY (ASC / HOSPITAL)	INPATIENT HOSPITAL	EMERGENCY ROOM FACILITY	URGENT CARE	PHARMACY	
										RX DED. (SINGLE / FAMILY)	RX DRUG TIER 1 / 2 / 3 / 4
STANDARD PLAN DESIGNS OFFERED ONLY ON FULL PPO NETWORK[2] THROUGH HEALTH NET LIFE INSURANCE COMPANY											
Platinum 90 PPO 0/15 + Child Dental	$0	$4,500 / $9,000	10%	$15 / $30	$15 / $30	10% / 10%	10%	$150	$15	$0	$5 / $15 / $25 / 10%[3]
Gold 80 PPO 250/25 + Child Dental	$250 / $500	$7,800 / $15,600	20%	$25[4] / $50[4]	$25[4] / $65[4]	20%[4] / 20%[4]	20%	$250	$25[4]	$0	$15 / $50 / $80 / 20%[3]
Silver 70 PPO 2250/50 + Child Dental	$2,250 / $4,500	$7,800 / $15,600	20%	$50[4] / $85[4]	$40[4] / $85[4]	20%[4] / 20%[4]	20%	$400	$50[4]	$300 / $600	$17 / $65 / $90 / 20%[3]
Bronze 60 PPO 6300/65 + Child Dental	$6,300 / $12,600	$7,800 / $15,600	40%	$65[6] / $95[6]	$40[4] / 40%	40% / 40%	40%	40%	$65[6]	$500 / $1,000	$18 / 40%[5] / 40%[5] / 40%[5]
ALTERNATE PLAN DESIGNS OFFERED ON FULL PPO AND ENHANCEDCARE PPO NETWORKS[2] THROUGH HEALTH NET LIFE INSURANCE COMPANY											
Platinum 90 PPO 250/15 + Child Dental Alt	$250 / $500	$3,800 / $7,600	10%	$15[4] / $30[4]	$30[4] / $30[4]	10% / 10%	10%	10%	$30[4]	$0	$10 / $35 / $60 / 10%[3]
Gold 80 PPO 0/30 + Child Dental Alt	$0	$7,400 / $14,800	30%	$30 / $50	$30 / $40	30% / 30%	30%	30%	$50	$0	$15 / $40 / $70 / 30%[3]
Gold 80 PPO 500/20 + Child Dental Alt	$500 / $1,000	$7,400 / $14,800	30%	$20[4] / $40[4]	$30[4] / $40[4]	30% / 30%	30%	30%	$40[4]	$250 / $500	$15[4] / $40 / $70 / 30%[3]
Gold 80 PPO 1000/30 + Child Dental Alt	$1,000 / $2,000	$7,400 / $14,800	30%	$30[4] / $50[4]	$30[4] / $40[4]	30% / 30%	30%	30%	$50[4]	$250 / $500	$15[4] / $40 / $70 / 30%[3]
Gold 80 Value PPO 750/15 + Child Dental Alt	$750 / $1,500	$7,600 / $15,200	30%	$15[4] / $30	$25 / $25	30% / 30%	30%	$250	$30	$750 / $1,500 Integrated med / Rx ded.	$15[4] / $40 / $70 / 30%[3]
Silver 70 PPO 2250/55 + Child Dental Alt	$2,250 / $4,500	$7,800 / $15,600	40%	$55[4] / $80[4]	$40[4] / $65	40% / 40%	40%	40%	$80[4]	$300 / $600	$19[4] / $65 / $85 / 40%[3]
Silver 70 Value PPO 1700/50 + Child Dental Alt	$1,700 / $3,400	$7,800 / $15,600	40%	$50[4] / $75	$40 / $50	40% / 40%	40%	40%	$75	$1,700 / $3,400 Integrated med / Rx ded.	$19[4] / $65 / 40%[3] / 40%[3]
Silver 70 HDHP PPO 1400/40% + Child Dental Alt	$1,400 / $2,800	$6,850 / $13,700	40%	40% / 40%	40% / 40%	40% / 40%	40%	40%	40%	$1,400 / $2,800 Integrated med / Rx ded .	$19 / $65 / $85 / 40%[3]
Bronze 60 HDHP PPO 5600/20% + Child Dental Alt	$5,600 / $11,200	$6,850 / $13,700	20%	20% / 20%	20% / 20%	20% / 20%	20%	20%	20%	$5,600 / $11,200 Integrated med / Rx ded.	$5 / $15 / $40 / 20%[5]

(continued)

Plan name	Member(s) responsibility										
	DEDUCTIBLE (SINGLE / FAMILY)	OUT-OF-POCKET MAXIMUM (SINGLE / FAMILY)	COINSURANCE	OFFICE / SPECIALIST VISIT	LAB / X-RAYS	OUTPATIENT SURGERY (ASC / HOSPITAL)	INPATIENT HOSPITAL	EMERGENCY ROOM FACILITY	URGENT CARE	PHARMACY	
										RX DED. (SINGLE / FAMILY)	RX DRUG TIER 1 / 2 / 3 / 4
PLAN DESIGNS OFFERED ON PURECARE HSP[2] AVAILABLE THROUGH HEALTH NET OF CALIFORNIA, INC.											
PureCare Platinum 90 HSP 0/15 + Child Dental	$0	$4,500 / $9,000	10%	$15 / $30	$15 / $30	10% / 10%	10%	$150	$15	$0	$5 / $15 / $25 / 10%[3]
PureCare Gold 80 HSP 250/25 + Child Dental	$250 / $500	$7,800 / $15,600	20%	$25[4] / $50[4]	$25[4] / $65[4]	20%[4] / 20%[4]	20%	$250	$25[4]	$0	$15 / $50 / $80 / 20%[3]
PureCare Silver 70 HSP 2250/50 + Child Dental	$2,250 / $4,500	$7,800 / $15,600	20%	$50[4] / $85[4]	$40[4] / $85[4]	20%[4] / 20%[4]	20%	$400	$50[4]	$300 / $600	$17 / $65 / $90 / 20%[3]
PureCare Bronze 60 HSP 6300/65 + Child Dental	$6,300 / $12,600	$7,800 / $15,600	40%	$65[6] / $95[6]	$40[4] / 40%	40% / 40%	40%	40%	$65[6]	$500 / $1,000	$18 / 40%[5] / 40%[5] / 40%[5]

Infertility benefits are available on all plans at an additional cost.

[2]**Counties available:** Full PPO – Available in all counties.
EnhancedCare PPO: Los Angeles County.
Full HMO, WholeCare HMO, PureCare HSP: All or parts of Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, and Yolo counties.
SmartCare HMO: All or parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
Salud HMO y Más: All or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties.
CommunityCare HMO: Los Angeles, Orange and San Diego counties.

[3]Maximum copayment after deductible (if any) of $250 for an individual prescription of up to a 30-day supply.

[4]Deductible waived.

[5]Maximum copayment after deductible (if any) of $500 for an individual prescription of up to a 30-day supply.

[6]Visits 1–3: The calendar year deductible is waived (combined between office visits, urgent care, prenatal and postnatal visits, and outpatient mental health/substance abuse).
Visits 4–unlimited: The calendar year deductible applies.

Health Net PPO Insurance Plans Via Covered California™

PEACE OF MIND FOR EMPLOYEES

Health Net Life Insurance Company offers a range of small business group plans through **Covered California™ for Small Business**. For 2019, employers who want to buy via Covered California have their choice of our Full PPO plans listed below:

- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 0/30 + Child Dental Alt
- Gold 80 PPO 250/25 + Child Dental
- Gold 80 Value PPO 750/15 + Child Dental Alt
- Silver 70 PPO 2250/50 + Child Dental
- Silver 70 Value PPO 1700/50 + Child Dental Alt
- Silver 70 HDHP PPO 1400/40% + Child Dental Alt
- Bronze 60 PPO 6300/65 + Child Dental
- Bronze 60 HDHP PPO 5600/20% + Child Dental Alt

The EnhancedCare PPO plans listed below are also available via Covered California for groups in Los Angeles (regions 15 and 16). The plan designs match the Full Network PPO versions. What differs is the network – EnhancedCare PPO – a tailored PPO network purposely crafted for small employers in Los Angeles. EnhancedCare PPO includes many of the valuable product features enjoyed on the Full PPO network, in addition to specialized high-touch support through our Health Benefit Navigator Team, all at a lower premium.

- EnhancedCare Platinum 90 PPO 250/15 Child Dental Alt
- EnhancedCare Gold 80 PPO 1000/30 Child Dental Alt
- EnhancedCare Silver 70 PPO 2250/55 Child Dental Alt
- EnhancedCare Silver 70 HDHP PPO 1400/40% Child Dental Alt
- EnhancedCare Bronze 60 HDHP PPO 5600/20% Child Dental Alt

Small businesses that buy through Covered California may qualify for a tax credit of up to 50% of the business' share of employee premiums. Here's how:

- Employers must have no more than 25 full-time equivalent employees (FTEs).
- Average employee wages must be under $50,000.
- Employers must contribute at least 50% of each employee's premium.

Small business employers can still deduct the rest of their premium costs not covered by the tax credit.

The premium tax credit applies only to small businesses participating in Covered California.

Ancillary Programs

Health Net brings together dental, vision, chiropractic, life, and AD&D programs so you and your clients can design a well-rounded employee benefits package.

Add Value with Ancillary Benefits

CREATE CUSTOM SOLUTIONS WITH THESE AFFORDABLE OPTIONS

Dental, Vision, Chiropractic, Life, and AD&D.

It's easy to design a well-rounded benefits package with Health Net. We offer a number of options to enhance our medical plans, so that members can design a custom plan that meets their unique health needs.

Dental plans that make them smile

Health Net offers a choice of HMO and PPO dental plan designs for individual or family coverage, along with access to one of the largest dental networks in California. Health Net Dental HMO and Dental PPO plans include most dental services. Members may purchase any of our dental plans on a standalone basis or they may pair them with a medical plan bought directly through Health Net. Pediatric dental coverage (ages newborn through 18) is included on all medical plans purchased through Health Net.

Dental plan highlights

DENTAL HMO

Health Net Dental HMO (DHMO) plans[7] give members access to an extensive network of providers and the convenience of having a set copayment for many dental services. Two DHMO plans are available – HN Plus 150 and HN Plus 225. DHMO plans include:

- Access to more than 3,000 DHMO providers in California.
- Added cleanings and adult fluoride.
- Material upgrades, such as porcelain and semiprecious or precious metal molar crowns.
- General anesthesia, and cosmetic and elective dentistry – services typically not covered under most other carriers' dental plans.
- Implants.

Health Net DHMO plans may be purchased separately or as a dual choice with Health Net Dental PPO plans.

DENTAL PPO

Health Net offers a range of affordable, flexible Dental PPO plans (DPPO).[8] DPPO plans include:

- Large statewide and national network of Dental PPO providers, which includes more than 52,000 providers in California and over 330,200 providers nationwide.
- Periodontics, endodontics and oral surgery are covered services on the Classic plans.
- Classic plans reimburse out-of-network benefits at usual, customary and reasonable (UCR)[9] amounts.
- Essential plans reimburse out-of-network benefits on a limited fee schedule.
- No waiting periods on any of our DPPO plans.

(continued)

[7]Health Net Dental HMO plans, other than pediatric dental, are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net.

[8]Health Net Dental PPO and indemnity plans, other than pediatric dental, are underwritten by Unimerica Life Insurance Company. Unimerica Life Insurance Company is not affiliated with Health Net.

[9]Usual, Customary and Reasonable (UCR) is the maximum allowable amount for a dental care service, determined by FAIR Health, Inc., on the basis of the fee usually charged by the provider and data obtained by FAIR Health, Inc. regarding fees charged by providers of similar training and experience for the same service within the same geographic area.

- All Health Net DPPO plans offer pregnant women added cleanings and periodontal maintenance when medically necessary. These services are not subject to the deductible and do not apply to the calendar year maximum.
- Members and dependents receive the full amount of the orthodontia lifetime maximum even if they started treatment under another carrier's dental PPO plan. This applies only to DPPO plans with orthodontia coverage.

Underwriting highlights

- Dual option available – group may select 2 DPPO plans, 2 DHMO plans, or 1 DHMO and 1 DPPO plan. (Please see "Small Business Group Dental and Vision buy-up guidelines" to determine if the group qualifies for dual option.)
- Voluntary DPPO plans without orthodontia are available to groups with at least two enrolled members.
- Voluntary DPPO plans with orthodontia are available to groups of 10 or more enrolled members.

See dental benefit grids on page 60.

Our vision plans have a clear advantage

Pediatric vision coverage (ages newborn through 18) is included on all medical plans. We also offer adult PPO Vision plans for ages 19 and older. These plans provide the convenience of a large national network, hassle free setup, administrative processing, and:

- A diverse network of independent and retail providers with over 10,500 vision providers in California and over 87,500 vision providers nationwide, including LensCrafters.
- Low copayments.
- Members and dependents can see any provider they choose, either in-network or out-of-network.
- Discounts of 5–15% on LASIK and PRK from U.S. Laser Network.[10]

In addition to our current offerings, Health Net is adding four new plans in 2020 that add versatility and greater vision coverage options! You can now pick from five different full service plans, one materials only plan and one exam only plan.

See vision benefit grids on page 63.

Chiropractic coverage

Your clients can enhance their HMO or PureCare HSP medical benefits with Health Net's affordable, quality chiropractic coverage. This service is provided through American Specialty Health Plans of California, Inc. (ASH Plans), a wholly owned subsidiary of American Specialty Health, Incorporated.

Employers can add chiropractic coverage with their purchase of a small business group medical plan. This coverage does not come standalone.[11]

See chiropractic benefit grid on page 65.

Chiropractic benefits are included with many of our PPO and EnhancedCare PPO plans.[12]

There's no need to buy extra coverage!

- **Platinum $250/15, Gold 0/30, Gold 500/20, Gold 1000/30, Silver 2250/55, and Value plans: $25 copayment per visit, 12 visits per year, no deductible**
- **HDHP plans: $25 copayment per visit, unlimited visits, deductible applies**

Plus! You can pair one of these PPOs with any of our HMO or HSP plan designs whether or not you want to buy chiropractic coverage.

[10]Members receive a 15% discount on the retail price or 5% off the promotional price of LASIK or PRK laser vision correction procedures. LASIK and PRK correction procedures are provided by U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.

[11]Chiropractic care is offered by Health Net of California, Inc. for HMO and HSP plans. Chiropractic care is underwritten by Health Net Life Insurance Company for PPO insurance plans. Chiropractic care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[12]Chiropractic services are neither covered nor available for purchase on Health Net's four "Standard" PPO plans: Platinum 0/15, Gold 250/25, Silver 2250/50, and Bronze 6300/65.

Life and AD&D

Many small businesses want an employee benefits package that includes group term life and accidental death & dismemberment (AD&D) insurance with desirable benefit levels. This allows a small business employer to:

- Enhance their benefit package.
- Offer life insurance benefits at economical rates.

One way employers can enhance their benefits package and lower administrative costs is to consolidate health and life insurance carriers. This removes some of the extra administrative costs that come with managing an employee benefits package. Health Net Life Insurance Company underwrites Group Term Life Benefit Insurance, Accidental Death & Dismemberment, and Dependent Life Insurance.

GROUP LIFE PLAN FEATURES

- **Waiver of premium provision** – A life benefit can be extended during a period of total disability under terms specified in the group Certificate of Insurance.[13]
- **Accelerated death benefit** – Provides financial protection to the insured in time of need, while also protecting the interest of the beneficiary. The accelerated benefit is a portion of the basic life insurance amount and is payable in a lump sum.
- **Conversion privilege** – A conversion privilege to whole life insurance is available to certain members whose coverage terminates due to reasons specified in the group policy.

Accidental Death & Dismemberment (AD&D)

These benefits are usually included as part of the group life insurance policy. Health Net Life Insurance Company does not offer AD&D benefits on a standalone basis.

- Benefit is payable as a result of an accidental loss of life or any of the physical losses specified in the group policy.
- The maximum benefit amount is equal to the basic life amount shown in the policy.
- This maximum benefit amount is payable for loss of life. It can also be payable for:
  - Loss of sight in both eyes.
  - Loss of both hands or both feet, or any two or more of these physical losses in the same accident.
- One half of the maximum benefit amount is payable for:
  - Loss of one hand.
  - Loss of one foot.
  - Loss of sight in one eye.

Group Term Life Insurance

LIFE OPTIONS

Option A	$15,000 flat amount for all employees
Option B	$25,000 flat amount for all employees (15–100 employees)
Option C	$50,000 flat amount for all employees (25–100 employees)

[13]Group Term Life, Supplemental Group Term Life and AD&D products are underwritten by Health Net Life Insurance Company, a subsidiary of Health Net, LLC.

HMO Portfolio

HMO Platinum $10

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $10
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$2,500 / $5,000
Professional services[1] Office visit copay	$10
Specialist visit	$30
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$10
Rehabilitation and habilitation therapy	$10
X-ray / Laboratory procedures	$10 / $10
Complex radiology services (MRI, CT, PET)	$100
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$40 / $100
Hospital services Inpatient hospital	$250 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$100
Urgent care	$30
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$250 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$10
Other services Durable medical equipment	10%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Platinum $20

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $20
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$3,000 / $6,000
Professional services[1] Office visit copay	$20
Specialist visit	$40
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$20
Rehabilitation and habilitation therapy	$20
X-ray / Laboratory procedures	$10 / $10
Complex radiology services (MRI, CT, PET)	$150
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$200 / $500
Hospital services Inpatient hospital	$350 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$150
Urgent care	$40
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$350 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20
Other services Durable medical equipment	20%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Platinum $30

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $30
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$2,250 / $4,500
Professional services[1] Office visit copay	$30
Specialist visit	$50
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$30
X-ray / Laboratory procedures	$50 / $20
Complex radiology services (MRI, CT, PET)	$250
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$150 / $150
Hospital services Inpatient hospital	$500 per day (4 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$250
Urgent care	$30
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$500 per day (4 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $20 / $30
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $30

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $30
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,000 / $12,000
Professional services[1] Office visit copay	$30
Specialist visit	$50
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$30
X-ray / Laboratory procedures	$40 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$360 / $900
Hospital services Inpatient hospital	$750 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$50
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $35

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $35
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,000 / $12,000
Professional services[1] Office visit copay	$35
Specialist visit	$55
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$35
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$480 / $1,200
Hospital services Inpatient hospital	$750 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$55
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$35
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $40

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $40
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,500 / $13,000
Professional services[1] Office visit copay	$40
Specialist visit	$60
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$40
X-ray / Laboratory procedures	$40 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$440 / $1,100
Hospital services Inpatient hospital	$750 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$60
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$40
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $50

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$7,000 / $14,000
Professional services[1] Office visit copay	$50
Specialist visit	$70
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$50
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$480 / $1,200
Hospital services Inpatient hospital	$750 per day (4 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$70
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (4 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$200 / $400
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $50 / $70
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Silver $50

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Silver $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit copay	$50
Specialist visit	$70
Telehealth services through Teladoc[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$50
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 50%
Hospital services Inpatient hospital	50%
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	50%
Urgent care	$70
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50
Other services Durable medical equipment	50%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$500 / $1,000
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$20 (ded. waived) / 50% / 50%
Tier 4 Specialty drugs[9]	50%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

Salud HMO y Más – SIMNSA network

SIMNSA NETWORK BENEFITS ARE AVAILABLE WITH ANY OF THE SALUD HMO Y MÁS PLANS.

Available with the following networks: Full Network HMO, WholeCare HMO, SmartCare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	SIMNSA[12]
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$1,500 / $4,500[13]
Professional services[1] Office visit copay	$5
Specialist visit	$5
Telehealth services through Teladoc[2]	Not covered
MinuteClinic[3]	Not covered
Rehabilitation and habilitation therapy	$5
X-ray / Laboratory procedures	$0 / $0
Complex radiology services (MRI, CT, PET)	$0
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$0 / $0
Hospital services Inpatient hospital	$0
Skilled nursing facility	$0
Emergency services Emergency room (copay waived if admitted)	$10
Urgent care	$10
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$0[14]
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$5
Other services Durable medical equipment	$0
Acupuncture (medically necessary)[5]	Not covered
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$0
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $5 / $5
Tier 4 Specialty drugs[9]	$5
Pediatric dental[10] Diagnostic and preventive services	Not covered
Pediatric vision[11] Routine eye exam	Not covered
Glasses (limitations apply)	Not covered

BKT033351EL00 (1/20)

CommunityCare HMO Portfolio

CommunityCare Silver $50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	CommunityCare Silver $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$1,750 / $3,500
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit copay	$50 (ded. waived)
Teladoc consultation telehealth services[2]	$0 (ded. waived)
Specialist visit	$70 (ded. waived)
Rehabilitation and habilitation therapy	$50 (ded. waived)
MinuteClinic[3]	$30 (ded. waived)
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	$25 per day (ded. waived)
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	$70 (ded. waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10 (ded. waived)
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	$250 / $500
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

CommunityCare Bronze 60 HMO 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	CommunityCare HMO Silver $20
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$6,300 / $12,600
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit copay	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Teladoc consultation telehealth services[2]	$0 (ded. waived)
Specialist visit	Visits 1-3 $95 (ded. waived) / Visits 4+ $95 (ded. applies)[12]
Rehabilitation and habilitation therapy	$65 (ded.waived)
MinuteClinic[3]	$30 (ded. waived)
X-ray / Laboratory procedures	40% / $40 (ded. waived)
Complex radiology services (MRI, CT, PET)	40%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	40%
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded.waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	$500 / $1,000
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

PureCare HSP Portfolio

PureCare Platinum 90 HSP 0/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Platinum 90 HSP 0/15
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$4,500 / $9,000
Professional services[1] Office visit	$15
Specialist visit	$30
Telehealth services through Teladoc[2]	$0
Rehabilitation and habilitation therapy	$15
X-ray / Laboratory procedures	$30 / $15
Complex radiology services (MRI, CT, PET)	10%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%
Hospital services Inpatient hospital	10%
Skilled nursing facility	10%
Emergency services Emergency room (copay waived if admitted)	$150
Urgent care	$15
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	10%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15
Other services Durable medical equipment	10%
Acupuncture (medically necessary)[5]	$15
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $15 / $25
Tier 4 Specialty drugs[9]	10%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

PureCare Gold 80 HSP 250/25

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Gold 80 HSP 250/25
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$250 / $500
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit	$25 (ded. waived)
Specialist visit	$50 (ded. waived)
Telehealth services through Teladoc[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$25 (ded. waived)
X-ray / Laboratory procedures	$65 (ded. waived) / $25 (ded. waived)
Complex radiology services (MRI, CT, PET)	20% (ded. waived)
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived)/ 20% (ded. waived)
Hospital services Inpatient hospital	20%
Skilled nursing facility	20%
Emergency services Emergency room (copay waived if admitted)	$250
Urgent care	$25 (ded . waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$25 (ded. waived)
Other services Durable medical equipment	20% (ded. waived)
Acupuncture (medically necessary)[5]	$25 (ded. waived)
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $80
Tier 4 Specialty drugs[9]	20%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

PureCare Silver 70 HSP 2250/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Silver 70 HSP 2250/50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$2,250 / $4,500
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit	$50 (ded. waived)
Specialist visit	$85 (ded. waived)
Telehealth services through Teladoc[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$50 (ded. waived)
X-ray / Laboratory procedures	$85 (ded. waived) / $40 (ded. waived)
Complex radiology services (MRI, CT, PET)	20% (ded. waived)
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived) / 20% (ded. waived)
Hospital services Inpatient hospital	20%
Skilled nursing facility	20%
Emergency services Emergency room (copay waived if admitted)	$400
Urgent care	$50 (ded. waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)
Other services Durable medical equipment	20% (ded. waived)
Acupuncture (medically necessary)[5]	$50 (ded. waived)
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	$300 / $600
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$17 / $65 / $90
Tier 4 Specialty drugs[9]	20%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

PureCare Bronze 60 HSP 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Bronze 60 HSP 6300/65
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$6,300 / $12,600
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Specialist visit	Visits 1–3: $95 (ded. waived) / visits 4+: $95[3]
Telehealth services through Teladoc[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$65 (ded. waived)
X-ray / Laboratory procedures	40% / $40 (ded. waived)
Complex radiology services (MRI, CT, PET)	40%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	40%
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%[3]
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded. waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Prescription drug coverage[7,8] Brand-name calendar year deductible (single / family)	$500 / $1,000
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

PPO Portfolio

Platinum 90 PPO 0/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	N/A	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$4,500 / $9,000	$9,000 / $18,000
Professional services Office visit[7]	$15	50%
Specialist visit	$30	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	$15	50%
X-ray/Laboratory procedures	$30 / $15	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	$150	$150 (ded. waived)
Urgent care	$15	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15	50%
Other services Durable medical equipment	10%	50%
Acupuncture (medically necessary)[11]	$15	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $15 / $25	Not covered
Tier 4 Specialty drugs[15]	10%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 250/25

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$250 / $500	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$25 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$25 (ded. waived)	50%
X-ray/Laboratory procedures	$65 (ded. waived) / $25 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	20% (ded. waived)	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived) / 20% (ded. waived)	50% / 50%
Hospital services Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$250	$250
Urgent care	$25 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$25 (ded. waived)	50%
Other services Durable medical equipment	20% (ded. waived)	50%
Acupuncture (medically necessary)[11]	$25 (ded. waived)	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $80	Not covered
Tier 4 Specialty drugs[15]	20%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Silver 70 PPO 2250/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$85 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	50%
X-ray/Laboratory procedures	$85 (ded. waived) / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	20% (ded. waived)	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived) / 20% (ded. waived)	50% / 50%
Hospital services Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$400	$400
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	20% (ded. waived)	50%
Acupuncture (medically necessary)[11]	$50 (ded. waived)	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$300 / $600 Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$17 / $65 / $90	Not covered
Tier 4 Specialty drugs[15]	20%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Bronze 60 PPO 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$6,300 / $12,600	$12,600 / $25,200
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Specialist visit	Visits 1-3 $95 (ded. waived) / Visits 4+ $95[10]	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$65 (ded. waived)	50%
X-ray/Laboratory procedures	40% / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$500 / $1,000 Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Platinum 90 PPO 250/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$250 / $500	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$3,800 / $7,600	$9,000 / $18,000
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	50%
X-ray/Laboratory procedures	$30 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	10%	10%
Urgent care	$30 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	10%	50%
Acupuncture (medically necessary)[11]	$15 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $35 / $60	Not covered
Tier 4 Specialty drugs[15]	10%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 0/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$0	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$30	50%
Specialist visit	$50	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	$30	50%
X-ray/Laboratory procedures	$40 / $30	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	$50	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$30	50%
Chiropractic care	$25 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 500/20

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$500 / $1,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$20 (ded. waived)	50%
Specialist visit	$40 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$20 (ded. waived)	50%
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$40 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$20 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 1000/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,000 / $2,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$30 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$30 (ded. waived)	50%
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$30 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 Value PPO 750/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$750 / $1,500	$2,250 / $4,500
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	50%
X-ray/Laboratory procedures	$25 / $25	50% / 50%
Complex radiology services (MRI, CT, PET)	$150	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	$250	$250
Urgent care	$30	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$15 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$750 / $1,500 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Silver 70 PPO 2250/55

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$55 (ded. waived)	50%
Specialist visit	$80 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$55 (ded. waived)	50%
X-ray/Laboratory procedures	$65 / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$80 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$55 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	$55 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $85	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Silver 70 Value PPO 1700/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,700 / $3,400	$3,400 / $6,800
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$75	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	50%
X-ray/Laboratory procedures	$50 / $40	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$75	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	$50 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$1,700 / $3,400 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / 40%	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Silver 70 HDHP PPO 1400/40%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4,5]	$1,400 / $2,800	$2,800 / $5,600
Out-of-pocket maximum (single / family)[6]	$6,850 / $13,700	$13,700 / $27,400
Professional services Office visit[7]	40%	50%
Specialist visit	40%	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	40%	50%
X-ray/Laboratory procedures	40% / 40%	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	40%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	40%	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	40%	50%
Chiropractic care	$25 (unlimited visits)	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$1,400 / $2,800 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 / $65 / $85	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Bronze 60 HDHP PPO 5600/20%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$5,600 / $11,200	$11,200 / $22,400
Out-of-pocket maximum (single / family)[6]	$6,850 / $13,700	$13,700 / $27,400
Professional services Office visit[7]	20%	50%
Specialist visit	20%	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	20%	50%
X-ray/Laboratory procedures	20% / 20%	50% / 50%
Complex radiology services (MRI, CT, PET)	20%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% / 20%	50% / 50%
Hospital services Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	20%	20%
Urgent care	20%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	20%	50%
Other services Durable medical equipment	20%	50%
Acupuncture (medically necessary)[11]	20%	50%
Chiropractic care	$25 (unlimited visits)	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$5,600 / $11,200 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $15 / $40	Not covered
Tier 4 Specialty drugs[15]	20%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10%
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare PPO Portfolio

EnhancedCare Platinum 90 PPO 250/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$250 / $500	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$3,800 / $7,600	$9,000 / $18,000
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	Not covered
X-ray/Laboratory procedures	$30 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	10%	10%
Urgent care	$30 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	10%	Not covered
Acupuncture (medically necessary)[10]	$15 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $35 / $60	Not covered
Tier 4 Specialty drugs[14]	10%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 0/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$0	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$30	50%
Specialist visit	$50	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	$30	Not covered
X-ray/Laboratory procedures	$40 / $30	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	$50	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$30	Not covered
Chiropractic care	$25 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 500/20

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$500 / $1,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$20 (ded. waived)	50%
Specialist visit	$40 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$20 (ded. waived)	Not covered
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$40 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$20 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 1000/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,000 / $2,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,400 / $14,800	$14,800 / $29,600
Professional services Office visit[7]	$30 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$30 (ded. waived)	Not covered
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$30 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 Value PPO 750/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$750 / $1,500	$2,250 / $4,500
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	Not covered
X-ray/Laboratory procedures	$25 / $25	50% / 50%
Complex radiology services (MRI, CT, PET)	$150	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	$250	$250
Urgent care	$30	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$15 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$750 / $1,50 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 PPO 2250/55

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$55 (ded. waived)	50%
Specialist visit	$80 (ded. waived)	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$55 (ded. waived)	Not covered
X-ray/Laboratory procedures	$65 / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$80 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$55 (ded. waived)	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	$55 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $85	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 Value PPO 1700/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,700 / $3,400	$3,400 / $6,800
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$75	50%
Telehealth services through Teladoc[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	Not covered
X-ray/Laboratory procedures	$50 / $40	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$75	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	$50 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$1,700 / $3,400 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / 40%	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 HDHP 1400/40% PPO

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,400 / $2,800	$2,800 / $5,600
Out-of-pocket maximum (single / family)[5,6]	$6,850 / $13,700	$13,700 / $27,400
Professional services Office visit[7]	40%	50%
Specialist visit	40%	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	40%	Not covered
X-ray/Laboratory procedures	40% / 40%	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	40%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	40%	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	40%	Not covered
Chiropractic care	$25 (unlimited visits)	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$1,400 / $2,800 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 / $65 / $85	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Bronze 60 HDHP 5600/20% PPO

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$5,600 / $11,200	$11,200 / $22,400
Out-of-pocket maximum (single / family)[6]	$6,850 / $13,700	$13,700 / $27,400
Professional services Office visit[7]	20%	50%
Specialist visit	20%	50%
Telehealth services through Teladoc[8]	$0	Not covered
Rehabilitation and habilitation therapy	20%	Not covered
X-ray/Laboratory procedures	20% / 20%	50% / 50%
Complex radiology services (MRI, CT, PET)	20%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% / 20%	50% / 50%
Hospital services Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	20%	20%
Urgent care	20%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	20%	50%
Other services Durable medical equipment	20%	Not covered
Acupuncture (medically necessary)[10]	20%	Not covered
Chiropractic care	$25 (unlimited visits)	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$5,600 / $11,200 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $15 / $40	Not covered
Tier 4 Specialty drugs[14]	20%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10%
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Dental Plans

Dental HMO

Dental plan	Plan pays		Member pays			
	ORTHODONTIA	ANNUAL PLAN MAXIMUM	ANNUAL DEDUCTIBLE	CLEANINGS	EXAMS	X-RAYS
DHMO Plus 150	100% over $1,695	N/A	N/A	$0	$0	$0
DHMO Plus 225	100% over $1,695	N/A	N/A	$0	$0	$0

Category	Procedure code	Description	Member copay	
			DHMO Plus 150	DHMO Plus 225
Diagnostic	D0150	Comprehensive oral evaluation	$0	$0
	D0210	Intraoral X-rays – complete series	$0	$0
	D9491	Office visit (including all fees for sterilization and infection control)	$5	$5
Preventive	D1110	Prophylaxis (cleaning) – adult	$0	$0
	D1110	Additional prophylaxis (up to 2 per year) – adult	$20	$35
	D1204	Topical application of fluoride – adult	$0	$0
Restorative	D2150	Amalgam (silver filling) – two surfaces	$0	$0
	D2331	Composite (white filling) – two surfaces anterior	$0	$0
	D2392	Composite (white filling) – two surfaces posterior	$30	$45
Crowns and pontics	D2751[1]	Crown – porcelain fused to predominantly base metal	$150	$225
	D2960	Labial veneer (resin laminate) – chairside	$250	$250
	D2962	Labial veneer (porcelain laminate) – laboratory	$350	$350
Endodontics	D3320	Root canal – bicuspid (excluding final restoration)	$95	$125
	D3330	Root canal – molar (excluding final restoration)	$125	$210
Periodontics	D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$35	$40
Prosthodontics	D5110	Complete denture – upper	$175	$260
Implants	D6010	Surgical placement of implant body – endosteal implant	$1,950	$1,950
Oral surgery	D7220	Removal of impacted tooth – soft tissue	$35	$45
Orthodontics	D8070–80	Comprehensive orthodontic treatment – adult or child	$1,695	$1,695
Other general services	D9230	Nitrous oxide, analgesia, anxiolysis (inhalation)	$15 per half hour	$15 per half hour
	D9972	External bleaching (teeth whitening) – per arch	$125	$125

(continued)

Health Net Dental plans may be purchased on a standalone basis or in conjunction with a Health Net medical plan.

This is only a summary of benefits. Please refer to the *Certificate of Insurance* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Dental PPO

	DPPO Classic 4 1500		DPPO Classic 5 1500	
	IN-NETWORK	**OUT-OF-NETWORK**[2]	**IN-NETWORK**	**OUT-OF-NETWORK**[2]
Calendar year maximum	$1,500		$1,500	
Calendar year deductible	$50 single / $150 family	$75 single / $225 family	$50 single / $150 family	$75 single /$225 family
Preventive services (initial/routine oral exam, teeth cleaning and routine scaling, fluoride treatment, sealant – children under 15, space maintainers, X-rays as part of a general exam, emergency exam)	100% deductible waived		100% deductible waived	80% deductible waived
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics)	80% after deductible		80% after deductible	
Major services (crowns, removable and fixed bridges, complete and partial dentures)	50% after deductible		50% after deductible	
Orthodontia[3] (adult and child)	Not covered		50% after deductible / $1,500 lifetime maximum	

	DPPO Essential 2 1000		DPPO Essential 5 1500		DPPO Essential 6 1500	
	IN-NETWORK	**OUT-OF-NETWORK**[4]	**IN-NETWORK**	**OUT-OF-NETWORK**[4]	**IN-NETWORK**	**OUT-OF-NETWORK**[4]
Calendar year maximum	$1,000		$1,500		$1,500	
Calendar year deductible	$50 single / $150 family	$75 single / $225 family	$50 single / $150 family	$75 single / $225 family	$50 single / $150 family	$75 single / $225 family
Preventive services (initial/routine oral exam, teeth cleaning and routine scaling, fluoride treatment, sealant – children under 15, space maintainers, X-rays as part of a general exam, emergency exam)	100% deductible waived		100% deductible waived		100% deductible waived	
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics)	80% after deductible		80% after deductible		80% after deductible	
Major services (crowns, removable and fixed bridges, complete and partial dentures)	50% after deductible		50% after deductible		50% after deductible	
Orthodontia[3] (adult and child)	Not covered		50% after deductible / $1,500 lifetime maximum		Not covered	

Limitations	
Initial / routine oral exam	2 per consecutive 12 months
Teeth cleaning	2 per consecutive 12 months (additional services available for pregnant members)
Fluoride treatment	2 per consecutive 12 months, children under 16 years only
Sealants	1 per 36 months, children under 16 years on permanent molars only
Emergency treatment	For relief of pain only

See ancillary footnotes on page 79.

Health Net Dental plans may be purchased on a standalone basis or in conjunction with a Health Net medical plan.

This is only a summary of benefits. Please refer to the *Certificate of Insurance* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Vision and Chiropractic Plans

Vision

	Elite 1010-1		Supreme 010-2		Preferred 1025-2	
	MEMBER COST	**OON ALLOWANCE**	**MEMBER COST**	**OON ALLOWANCE**	**MEMBER COST**	**OON ALLOWANCE**
Exam with dilation as necessary	$10 copay	Up to $40	$0 copay	Up to $40	$10 copay	Up to $40
Standard plastic lenses Single vision	$10 copay	Up to $40	$10 copay	Up to $40	$25 copay	Up to $40
Lined bifocal	$10 copay	Up to $60	$10 copay	Up to $60	$25 copay	Up to $60
Lined trifocal	$10 copay	Up to $80	$10 copay	Up to $80	$25 copay	Up to $80
Lenticular lenses	$10 copay	Up to $80	$10 copay	Up to $80	$25 copay	Up to $80
Standard progressive lenses	$75 copay	Up to $60	$75 copay	Up to $60	$90 copay	Up to $60
Premium progressive lenses	$75, then 80% of total charges less $120 allowance	Up to $60	$75, then 80% of total charges less $120 allowance	Up to $60	$90, then 80% of total charges less $120 allowance	Up to $60
Frames Any frame available at a provider location	$0 copay, $150 retail allowance for any frame plus 20% off balance over allowance	Up to $45	$0 copay, $120 retail allowance for any frame plus 20% off balance over allowance	Up to $45	$0 copay, $100 retail allowance for any frame plus 20% off balance over allowance	Up to $45
Lens options UV coating	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Tint (solid and gradient)	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Standard scratch-resistant	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Standard polycarbonate	$40 copay	No discount	$40 copay	No discount	$40 copay	No discount
Standard anti-reflective	$45 copay	No discount	$45 copay	No discount	$45 copay	No discount
Other add-ons and services	20% discount	No discount	20% discount	No discount	20% discount	No discount
Contact lenses (in lieu of eyeglass lenses)	$120 allowance	No discount	$105 allowance	No discount	$90 allowance	No discount
Conventional	$0 copay, plus 15% discount off balance over allowance	Up to $105	$0 copay, plus 15% discount off balance over allowance	Up to $105	$0 copay, plus 15% discount off balance over allowance	Up to $105
Disposables	$0 copay, plus balance over allowance	Up to $105	$0 copay, plus balance over allowance	Up to $105	$0 copay, plus balance over allowance	Up to $105
Medically necessary	Paid in full	Up to $210	Paid in full	Up to $210	Paid in full	Up to $210
Laser vision correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No discount	15% off retail price or 5% off promotional price	No discount	15% off retail price or 5% off promotional price	No discount
Frequency Exam	Once every 12 months		Once every 12 months		Once every 12 months	
Lenses or contact lenses	Once every 12 months		Once every 12 months		Once every 12 months	
Frame	Once every 12 months		Once every 24 months		Once every 24 months	

(continued)

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

This is only a summary of benefits. Please refer to the *Certificate of Insurance* or *Evidence of Coverage* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Vision

	Preferred 1025-3		Preferred Value 10-3		Plus 20-1	
	MEMBER COST	**OON ALLOWANCE**	**MEMBER COST**	**OON ALLOWANCE**	**MEMBER COST**	**OON ALLOWANCE**
Exam with dilation as necessary	$10 copay	Up to $40	Not covered	Not covered	$20 copay	Up to $40
Standard plastic lenses Single vision	$25 copay	Up to $40	$10 copay	Up to $40	$50 copay	No discount
Lined bifocal	$25 copay	Up to $60	$10 copay	Up to $60	$70 copay	No discount
Lined trifocal	$25 copay	Up to $80	$10 copay	Up to $80	$105 copay	No discount
Lenticular lenses	$25 copay	Up to $80	$10 copay	Up to $80	Not covered	Not covered
Standard progressive lenses	$90 copay	Up to $60	$75 copay	Up to $60	$135 copay	No discount
Premium progressive lenses	$90, then 80% of total charges less $120 allowance	Up to $60	$75, then 80% of total charges less $120 allowance	Up to $60	Not covered	Not covered
Frames Any frame available at a provider location	$0 copay, $100 retail allowance for any frame plus 20% off balance over allowance	Up to $45	$0 copay, $100 retail allowance for any frame plus 20% off balance over allowance	Up to $45	35% discount off retail price	No discount
Lens options UV coating	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Tint (solid and gradient)	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Standard scratch-resistant	$15 copay	No discount	$15 copay	No discount	$15 copay	No discount
Standard polycarbonate	$40 copay	No discount	$40 copay	No discount	$40 copay	No discount
Standard anti-reflective	$45 copay	No discount	$45 copay	No discount	$45 copay	No discount
Other add-ons and services	20% discount	No discount	20% discount	No discount	20% discount	No discount
Contact lenses (in lieu of eyeglass lenses)	$90 allowance	No discount	$90 allowance	No discount	Not covered	Not covered
Conventional	$0 copay, plus 15% discount off balance over allowance	Up to $105	$0 copay, plus 15% discount off balance over allowance	Up to $105	Not covered	Not covered
Disposables	$0 copay, plus balance over allowance	Up to $105	$0 copay, plus balance over allowance	Up to $105	Not covered	Not covered
Medically necessary	Paid in full	Up to $210	Paid in full	Up to $210	Not covered	Not covered
Laser vision correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No discount	15% off retail price or 5% off promotional price	No discount	15% off retail price or 5% off promotional price	No discount
Frequency Exam	Once every 12 months		Not covered		Once every 12 months	
Lenses or contact lenses	Once every 24 months		Once every 24 months		Unlimited	
Frame	Once every 24 months		Once every 24 months		Unlimited	

(continued)

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

This is only a summary of benefits. Please refer to the *Certificate of Insurance* or *Evidence of Coverage* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Vision

	Exam only	
	MEMBER COST	**OON ALLOWANCE**
Exam with dilation as necessary	$0 copay	Up to $40
Standard plastic lenses Single vision	Not covered	Not covered
Lined bifocal	Not covered	Not covered
Lined trifocal	Not covered	Not covered
Lenticular lenses	Not covered	Not covered
Standard progressive lenses	Not covered	Not covered
Premium progressive lenses	Not covered	Not covered
Frames Any frame available at a provider location	Not covered	Not covered
Lens options UV coating	Not covered	Not covered
Tint (solid and gradient)	Not covered	Not covered
Standard scratch-resistant	Not covered	Not covered
Standard polycarbonate	Not covered	Not covered
Standard anti-reflective	Not covered	Not covered
Other add-ons and services	Not covered	Not covered
Contact lenses (in lieu of eyeglass lenses)	Not covered	Not covered
Conventional	Not covered	Not covered
Disposables	Not covered	Not covered
Medically necessary	Not covered	Not covered
Laser vision correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	No discount
Frequency Exam	Once every 24 months	
Lenses or contact lenses	Not covered	
Frame	Not covered	

Chiropractic[5]

	HMO[6]	CommunityCare HMO and PureCare HSP	Full Network and EnhancedCare PPO[7]
Copayment	$10	$10	$25
Deductible	N/A	Deductible waived	Non-HDHP: Deductible waived HDHP: Deductible applies
Visits	Unlimited	Unlimited	Non-HDHP: 12/year HDHP: Unlimited

See ancillary footnotes on page 79.

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered.

This is only a summary of benefits. Please refer to the *Certificate of Insurance* or *Evidence of Coverage* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Plan Choices by Region

Region		We offer...	With this network
1	**Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba counties**	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
	Nevada County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
2	**Marin, Napa, Solano, and Sonoma counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
3	**Sacramento, Placer, El Dorado, and Yolo counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
4	**San Francisco County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platium, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
5	**Contra Costa County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
6	**Alameda County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
7	**Santa Clara County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • SmartCare • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

(continued)

Region		We offer...	With this network
8	San Mateo County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
9	Santa Cruz County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
	Monterey and San Benito counties	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
10	Mariposa County	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
	San Joaquin, Stanislaus, Merced, and Tulare counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
11	Fresno, Kings and Madera counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
12	Santa Barbara and Ventura counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
	San Luis Obispo County	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
13	Mono, Inyo and Imperial counties	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
14	Kern County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • Salud HMO y Más
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

(continued)

Region		We offer...	With this network
15	**Los Angeles County: ZIP codes starting with 906–912, 915, 917, 918, 935**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Your choice of: • Full Network PPO • EnhancedCare PPO
16	**Los Angeles County: ZIP codes not in Region 15**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Your choice of: • Full Network PPO • EnhancedCare PPO
17	**San Bernardino and Riverside counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
18	**Orange County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
19	**San Diego County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

Plan Codes

Plan Name	Plan code without infertility	Plan code with infertility
CommunityCare HMO Silver $50	G2M	G2N
CommunityCare Bronze 60 HMO 6300/65 + Child Dental	G2I (india)	G2J
Full Network HMO Platinum $10	G41	G42
Full Network HMO Platinum $20	G43	G44
Full Network HMO Platinum $30	G45	G46
Full Network HMO Gold $30	G3P	G3Q
Full Network HMO Gold $35	G3R	G3S
Full Network HMO Gold $40	G3T	G3U
Full Network HMO Gold $50	G3V	G3W
Full Network HMO Silver $50	G49	G4B
WholeCare HMO Platinum $10	G3D	G3E
WholeCare HMO Platinum $20	G3F	G3G
WholeCare HMO Platinum $30	G3H	G3I
WholeCare HMO Gold $30	G2Y	G2Z
WholeCare HMO Gold $35	G30	G31
WholeCare HMO Gold $40	G32	G33
WholeCare HMO Gold $50	G34	G35
WholeCare HMO Silver $50	G3L	G3M
SmartCare HMO Platinum $10	G29	G2B
SmartCare HMO Platinum $20	G2C	G2D
SmartCare HMO Platinum $30	G2E	G2F
SmartCare HMO Gold $30	G21	G22
SmartCare HMO Gold $35	G23	G24
SmartCare HMO Gold $40	G25	G26
SmartCare HMO Gold $50	G27	G28
SmartCare HMO Silver $50	G2G	G2H
Salud HMO y Mas HMO Platinum $10	G4M	G4N
Salud HMO y Mas HMO Platinum $20	G4O	G4P
Salud HMO y Mas HMO Platinum $30	G4Q	G4R
Salud HMO y Mas HMO Gold $30	G4C	G4D
Salud HMO y Mas HMO Gold $35	G4E	G4F
Salud HMO y Mas HMO Gold $40	G4G	G4H
Salud HMO y Mas HMO Gold $50	G4I (india)	G4J
Salud HMO y Mas HMO Silver $50	G4U	G4V

(continued)

Plan Name	Plan code without infertility	Plan code with infertility
Platinum 90 PPO 0/15 + Child Dental	FZ8	FZ9
Platinum 90 PPO 250/15 + Child Dental Alt	FZB	FZC
Gold 80 PPO 0/30 + Child Dental	FYY	FYZ
Gold 80 PPO 250/25 + Child Dental Alt	FZ0	FZ1
Gold 80 PPO 500/20 + Child Dental Alt	FZ2	FZ3
Gold 80 PPO 1000/30 + Child Dental Alt	FZ4	FZ5
Gold 80 Value PPO 750/15 + Child Dental Alt	FZ6	FZ7
Silver 70 PPO 2250/50 + Child Dental	FZD	FZE
Silver 70 PPO 2250/55 + Child Dental Alt	FZF	FZG
Silver 70 HDHP PPO 1400/40% PPO + Child Dental Alt	FZH	FZI (india)
Silver 70 Value PPO 1700/50 + Child Dental Alt	FZJ	FZK
Bronze 60 HDHP 5600/20% + Child Dental Alt	FYW	FYX
Bronze 60 PPO 6300/65 + Child Dental	FYV	G1X
EnhancedCare Platinum 90 PPO 250/15 + Child Dental Alt	FZV	FZW
EnhancedCare Gold 80 PPO 0/30 + Child Dental Alt	FZN	FZO (opera)
EnhancedCare Gold 80 PPO 500/20 + Child Dental Alt	FZP	FZQ
EnhancedCare Gold 80 PPO 1000/30 + Child Dental Alt	FZR	FZS
EnhancedCare Gold 80 Value PPO 750/15 + Child Dental Alt	FZT	FZU
EnhancedCare Silver 70 PPO 2250/55 + Child Dental Alt	FZX	FZY
EnhancedCare Silver 70 HDHP PPO 1400/40% + Child Dental Alt	FZZ	G10
EnhancedCare Silver 70 Value PPO 1700/50 + Child Dental Alt	G11	G12
EnhancedCare Bronze 60 HDHP PPO 5600/20% + Child Dental Alt	FZL	FZM
PureCare Platinum 90 HSP 0/15 + Child Dental	G2U	G2V
PureCare Gold 80 HSP 250/25 + Child Dental	G2S	G2T
PureCare Silver 70 HSP 2250/50 + Child Dental	G2W	G2X
PureCare Bronze 60 HSP 6300/65 + Child Dental	G2Q	G2R

Infertility buy-up details

For HMO/HSP plans only

- There is an $8,500 lifetime maximum on infertility services and a separate $1,500 lifetime limit on prescription medications for infertility.
- Infertility benefits do not apply to the calendar year out-of-pocket maximum.

For PPO/EnhancedCare PPO insurance plans only

- There is a $2,000 lifetime maximum on infertility services and a separate $2,000 lifetime limit on prescription medications for infertility.
- Infertility benefits do not apply to the calendar year out-of-pocket maximum (with the exception of HDHP plans).

Footnotes

Platinum $10, Platinum $20, Platinum $30, Gold $30, Gold $35, Gold $40, Gold 50, Silver $50, and SIMNSA

[1]Preventive care services are covered for children and adults, as directed by your physician, 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). Preventive care services include, but are not limited to, periodic health evaluations; immunizations; and diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Telehealth services that are not provided by Teladoc are not covered. Teladoc consultation services do not cover: specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential abuse.

[3]MinuteClinics are not located in all California counties. Refer to www.minuteclinic.com for the most up-to-date locations.

[4]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Self-injectable drugs (other than insulin) are considered specialty drugs. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

[12]In Mexico, all providers, facilities and pharmacies must belong to the SIMNSA Network, except for emergency services.

[13]Any copayment or coinsurance paid for covered services in either the Salud Network or the SIMNSA Network will be credited to the individual OOPM of both networks.

[14]Mental health and substance abuse services must be provided by a SIMNSA provider.

CommunityCare HMO

[1]Preventive care services are covered for children and adults, as directed by your physician, 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). Preventive care services include, but are not limited to, periodic health evaluations; immunizations; and diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder and chemical dependency conditions. Teladoc services are not intended to replace services from your physician but are a supplemental service. Telehealth services that are not provided by Teladoc are not covered. Teladoc consultation services do not cover: specialist services, prescriptions for substances controlled by the DEA, non-therapeutic drugs, or certain other drugs which may be harmful because of the potential for abuse.

[3]MinuteClinics are not located in all California counties. Refer to www.minuteclinic.com for the most up-to-date locations.

[4]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Self-injectable drugs (other than insulin) are considered specialty drugs. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

[12](Bronze only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits, outpatient mental health/ substance abuse): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

PureCare HSP

[1]Preventive care services are covered for children and adults, as directed by your physician, based on the 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Telehealth services that are not provided by Teladoc are not covered. Teladoc consultation services do not cover: specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential abuse.

[3](Bronze only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits, outpatient mental health/ substance abuse): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

[4]Benefits are administered by MHN Services, an affiliated behavioral health administrative services company, which provides behavioral health services.

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. The brand-name prescription drug deductible, or medical deductible if applicable, must be paid before Health Net begins to pay for brand-name prescription drugs, including brand-name specialty drugs.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

PPO

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* (COI) for terms and conditions of coverage.

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the COI for details.

[2]Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3]Please refer to the COI for out-of-network reimbursement methodology.

[4]Any amount applied toward the calendar year deductible (if applicable) for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers. In addition, any amount applied toward the calendar year deductible for covered services and supplies received from an out-of-network provider will not apply toward the calendar year deductible for in-network providers. Unless otherwise specified, deductible applies to all services.

[5](Silver HDHP only) For single coverage, the deductible is $1,400. For family coverage, the deductible is $2,800, and there is no per member deductible accumulation/accrual. It is a single comprehensive family deductible.

[6]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and copayments or coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.

[7]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information about generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[8]Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Telehealth services that are not provided by Teladoc are not covered. Teladoc consultation services do not cover: specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential abuse.

[9]Benefits are administered by MHN Services, an affiliated behavioral health administrative services company, which provides behavioral services.

[10](Bronze non-HDHP plan only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

[11]Acupuncture care is underwritten by Health Net Life Insurance Company for PPO plans.

[12]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the COI for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your COI and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The COI is a legal, binding document. If the information in this brochure differs from the information in the COI, the COI controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[13]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[14](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[15]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[16]Pediatric dental PPO plans are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services (DBP). DBP is not affiliated with Health Net. See the plan's COI for details.

[17]Pediatric vision benefits are provided by Health Net Life Insurance Company. Health Net Life Insurance Company contracts with Envolve Vision Inc., to administer vision benefits.

EnhancedCare PPO

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* (COI) for terms and conditions of coverage.

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the COI for details.

[2]Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3]Please refer to the COI for out-of-network reimbursement methodology.

[4]Any amount applied toward the calendar year deductible (if applicable) for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers. In addition, any amount applied toward the calendar year deductible for covered services and supplies received from an out-of-network provider will not apply toward the calendar year deductible for in-network providers. Unless otherwise specified, deductible applies to all services.

[5](Silver HDHP only) For single coverage, the deductible is $1,400. For family coverage, the deductible is $2,800, and there is no per member deductible accumulation/accrual. It is a single comprehensive family deductible.

[6]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and copayments or coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.

[7]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information about generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[8]Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Telehealth services that are not provided by Teladoc are not covered. Teladoc consultation services do not cover: specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse.

[9]Benefits are administered by MHN Services, an affiliated behavioral health administrative services company, which provides behavioral services.

[10]Acupuncture care is underwritten by Health Net Life Insurance Company for EnhancedCare PPO plans.

[11]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the COI for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your COI and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The COI is a legal, binding document. If the information in this brochure differs from the information in the COI, the COI controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[12]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[13](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[14]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[15]Pediatric dental PPO plans are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services (DBP). DBP is not affiliated with Health Net. See the plan's COI for details.

[16]Pediatric vision benefits are provided by Health Net Life Insurance Company. Health Net Life Insurance Company contracts with Envolve Vision Inc., to administer vision benefits.

Ancillary

[1]There is a maximum charge of $150 in addition to the listed copayment if noble, high noble or titanium metal is used. Porcelain on molars is an additional charge of $75.

[2]Out-of-network benefits for the Classic plan are reimbursed at the Usual, Customary and Reasonable (UCR) amounts as determined by FAIR Health, Inc.

[3]For employer-paid DPPO plans, orthodontia is available for groups with 2–9 enrollees with proof of immediately prior indemnity orthodontia coverage or for groups of 10 or more enrollees. For voluntary DPPO plans, orthodontia is available for groups of 10 or more enrolled employees.

[4]Out-of-network benefits for Essential plans are based on the allowable amount applicable for the same service that would have been rendered by a network provider.

[5]Chiropractic care is offered by Health Net of California, Inc. for HMO and HSP plans. Chiropractic care is underwritten by Health Net Life Insurance Company for PPO insurance plans. Chiropractic care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]There is a $50 yearly chiropractic appliance allowance toward the purchase of medically necessary items. This can be used for supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts, and home traction units.

[7]The following PPO plans, on both Full and EnhancedCare PPO networks, include Chiropractic coverage: Platinum 250/15, Gold 0/30, Gold 500/20, Gold 1000/30, Gold Value 750/15, Silver 2250/55, Silver Value 1700/50, Silver HDHP 1400/40%, and Bronze HDHP 5600/20%.

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