Individual & Family EnhancedCare PPO Insurance Plans

Available through Health Net Life Insurance Company (Health Net)

For coverage, go to www.myhealthnetca.com to apply today!

Health Net®

Outline of Coverage and Exclusions and Limitations

Plans available in limited California counties[1]

Health Net Individual & Family Health Insurance Plans major medical expense coverage.

Read your Policy carefully

This outline of coverage provides a brief description of the important features of your Health Net EnhancedCare PPO Policy (Policy). This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and Health Net Life Insurance Company. It is, therefore, important that you read your Policy carefully!

[1]Health Net Life Insurance Company EnhancedCare PPO plans utilize the EnhancedCare PPO provider network. IFP EnhancedCare PPO plans are available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties.

Platinum 90 EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible	None	$5,000 single / $10,000 family
Out-of-pocket maximum[4]	$3,350 single / $6,700 family	$25,000 single / $50,000 family
Professional services Office visit	$15	50%
Teladoc consultation telehealth services[5]	$0	Not covered
Specialist consultation	$30	50%
Other practitioner office visit (including medically necessary acupuncture)	$15	50%
Preventive care services[6]	$0	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$30 / $15	50%
Imaging (CT/PET scans, MRIs)	10%	50%
Rehabilitation and habilitation therapy	$15	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	10%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	$150 facility / $0 physician	$150 facility (ded. waived) / $0 physician (ded. waived)
Urgent care	$15	50%
Ambulance services (ground and air)	$150	$150 (ded. waived)
Mental/Behavioral health / Substance use disorder services[7] Mental/Behavioral health / Substance use disorder services (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $0 Other than office visit: 10% up to $15	50%
Home health care services (100 visits/year)	10%	Not covered
Other services Durable medical equipment	10%	Not covered
Hospice service	$0	50%

(continued)

Platinum 90 EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drugs[8] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$5	Not covered
Tier II (non-preferred generics and preferred brands)	$15	Not covered
Tier III (non-preferred brands only)	$25	Not covered
Tier IV (Specialty drugs)	10% up to $250 / 30-day script	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9,11] Routine eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the policy for terms and conditions of coverage.

[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[5] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders 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. In addition, 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.

[6] 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.

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

[8] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[9] Pediatric dental and vision are included on all plans.

[10] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[11] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Gold 80 EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	None	$5,000 single / $10,000 family
Out-of-pocket maximum[4]	$6,000 single / $12,000 family	$25,000 single / $50,000 family
Professional services Office visit	$25	50%
Teladoc consultation telehealth services[5]	$0	Not covered
Specialist consultation	$55	50%
Other practitioner office visit (including medically necessary acupuncture)	$25	50%
Preventive care services[6]	$0	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$55 / $35	50%
Imaging (CT/PET scans, MRIs)	20%	50%
Rehabilitation and habilitation therapy	$25	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$325 facility / $0 physician	$325 facility (ded. waived) / $0 physician (ded. waived)
Urgent care	$25	50%
Ambulance services (ground and air)	$250	$250 (ded. waived)
Mental/Behavioral health / Substance use disorder services[7] Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $0 Other than office visit: 20% up to $25	50%
Home health care services (100 visits/year)	20%	Not covered
Other services Durable medical equipment	20%	Not covered
Hospice service	$0	50%

(continued)

Gold 80 EnhancedCare PPO (*continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drugs[8] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$15	Not covered
Tier II (non-preferred generics and preferred brands)	$55	Not covered
Tier III (non-preferred brands only)	$75	Not covered
Tier IV (Specialty drugs)	20% up to $250 / 30-day script	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9,11] Routine eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the policy for terms and conditions of coverage.

[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[5] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders 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. In addition, 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.

[6] 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.

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[8] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[9] Pediatric dental and vision are included on all plans.

[10] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[11] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Gold Value EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$1,000 single / $2,000 family	$5,000 single / $10,000 family
Out-of-pocket maximum[5]	$6,000 single / $12,000 family	$25,000 single / $50,000 family
Professional services Office visit	$20 (ded. waived)	50%
Teladoc consultation telehealth services[6]	$0 (ded. waived)	Not covered
Specialist consultation	$50 (ded. waived)	50%
Other practitioner office visit (including medically necessary acupuncture)	$20 (ded. waived)	50%
Preventive care services[7]	$0	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$55 / $35 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	20%	50%
Rehabilitation and habilitation therapy	$20 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$325 facility (ded. applies) / $0 physician (ded. waived)	$325 facility (ded. applies) / $0 physician (ded. waived)
Urgent care	$20 (ded. waived)	50%
Ambulance services (ground and air)	$250	$250
Mental/Behavioral health / Substance use disorder services[8] Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $20 (ded. waived) Other than office visit: 20% up to $20	50%
Home health care services (100 visits/year)	20%	Not covered
Other services Durable medical equipment	20%	Not covered
Hospice service	$0 (ded. waived)	50%

(continued)

Gold Value EnhancedCare PPO (*continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$500 single / $1,000 family	Not covered
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$10 (Rx ded. waived)	Not covered
Tier II (non-preferred generics and preferred brands)	$50 (after Rx ded.)	Not covered
Tier III (non-preferred brands only)	$85 (after Rx ded.)	Not covered
Tier IV (Specialty drugs)	20% up to $250 / 30-day script (after Rx ded.)	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[10,12] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

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[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers.

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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[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.

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[10] Pediatric dental and vision are included on all plans.

[11] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[12] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Silver 70 EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$2,500 single / $5,000 family	$5,000 single / $10,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,000 single / $14,000 family	$25,000 single / $50,000 family
Professional services Office visit	$35 (ded. waived)	50%
Teladoc consultation telehealth services[6]	$0 (ded. waived)	Not covered
Specialist consultation	$75 (ded. waived)	50%
Other practitioner office visit (including medically necessary acupuncture)	$35 (ded. waived)	50%
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$75 (ded. waived) / $35 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	$300 (ded. waived)	50%
Rehabilitation and habilitation therapy	$35 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20% (ded. waived)	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$350 facility (ded. waived) / $0 physician (ded. waived)	$350 facility (ded. waived) / $0 physician (ded. waived)
Urgent care	$35 (ded. waived)	50%
Ambulance services (ground and air)	$250	$250
Mental/Behavioral health / Substance use disorder services[8] Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $0 (ded. waived) Other than office visit: $0 (ded. waived)	50%
Home health care services (100 visits/year)	$45 (ded. waived)	Not covered
Other services Durable medical equipment	20% (ded. waived)	Not covered
Hospice service	$0 (ded. waived)	50%

(continued)

Silver 70 EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$130 single / $260 family	Not covered
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$15 (after Rx ded.)	Not covered
Tier II (non-preferred generics and preferred brands)	$55 (after Rx ded.)	Not covered
Tier III (non-preferred brands only)	$80 (after Rx ded.)	Not covered
Tier IV (Specialty drugs)	20% up to $250 / 30-day script (after Rx ded.)	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[10,12] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

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[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 policy for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible 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.

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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[12] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Silver 70 Off Exchange EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$2,500 single / $5,000 family	$5,000 single / $10,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,000 single / $14,000 family	$25,000 single / $50,000 family
Professional services Office visit	$35 (ded. waived)	50%
Teladoc consultation telehealth services[6]	$0 (ded. waived)	Not covered
Specialist consultation	$75 (ded. waived)	50%
Other practitioner office visit (including medically necessary acupuncture)	$35 (ded. waived)	50%
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$75 (ded. waived) / $35 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	$300 (ded. waived)	50%
Rehabilitation and habilitation therapy	$35 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20% (ded. waived)	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	$350 facility (ded. waived) / $0 physician (ded. waived)	$350 facility (ded. waived) / $0 physician (ded. waived)
Urgent care	$35 (ded. waived)	50%
Ambulance services (ground and air)	$255	$255
Mental/Behavioral health / Substance use disorder services[8] Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $0 (ded. waived) Other than office visit: $0 (ded. waived)	Office visit: 50% Other than office visit: 50%
Home health care services (100 visits/year)	$45 (ded. waived)	Not covered
Other services Durable medical equipment	20% (ded. waived)	Not covered
Hospice service	$0 (ded. waived)	50%

(continued)

Silver 70 Off Exchange EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$130 single / $260 family	Not covered
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$15 (after Rx ded.)	Not covered
Tier II (non-preferred generics and preferred brands)	$55 (after Rx ded.)	Not covered
Tier III (non-preferred brands only)	$80 (after Rx ded.)	Not covered
Tier IV (Specialty drugs)	20% up to $250 / 30-day script (after Rx ded.)	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[10,12] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

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

[9] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[10] Pediatric dental and vision are included on all plans.

[11] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[12] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Silver Value EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$4,500 single / $9,000 family	$9,000 single / $18,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,000 single / $14,000 family	$25,000 single / $50,000 family
Professional services Office visit	$45 (ded. waived)	50%
Teladoc consultation telehealth services[6]	$0 (ded. waived)	Not covered
Specialist consultation	$60 (ded. waived)	50%
Other practitioner office visit (including medically necessary acupuncture)	$45 (ded. waived)	50%
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$70 (ded. waived) / $35 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	$300	50%
Rehabilitation and habilitation therapy	$45 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	30%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	$350 facility (ded. applies) / $0 physician (ded. waived)	$350 facility (ded. applies) / $0 physician (ded. waived)
Urgent care	$45 (ded. waived)	50%
Ambulance services (ground and air)	$250	$250
Mental/Behavioral health / Substance use disorder services[8] Mental/Behavioral health / Substance use disorder services (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $45 (ded. waived) Other than office visit: $0 (ded. waived)	Office visit: 50% Other than office visit: 50%
Home health care services (100 visits/year)	30%	Not covered
Other services Durable medical equipment	30%	Not covered
Hospice service	$0 (ded. waived)	50%

(continued)

Silver Value EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$500 single / $1,000 family	Not covered
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands)	$15 (Rx ded. waived)	Not covered
Tier II (non-preferred generics and preferred brands)	$55 (after Rx ded.)	Not covered
Tier III (non-preferred brands only)	$85 (after Rx ded.)	Not covered
Tier IV (Specialty drugs)	30% up to $250 / 30-day script (after Rx ded.)	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[10,12] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the policy for terms and conditions of coverage.

[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible 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.

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[6] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders 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. In addition, 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.

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

[9] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[10] Pediatric dental and vision are included on all plans.

[11] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[12] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Bronze 60 EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$6,300 single / $12,600 family	$12,600 single / $25,200 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,000 single / $14,000 family	$25,000 single / $50,000 family
Professional services Office visit	Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[6]	50%
Teladoc consultation telehealth services[7]	$0 (ded. waived)	Not covered
Specialist consultation	Visits 1–3: $105 (ded. waived) / Visits 4+: $105 (ded. applies)[6]	50%
Other practitioner office visit (including medically necessary acupuncture)	Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[6]	50%
Preventive care services[8]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	100%[9] / $40 (ded. waived)	50% / 50%
Imaging (CT/PET scans, MRIs)	100%[9]	50%
Rehabilitation and habilitation therapy	$75 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	100%[9]	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	100%[9]	50%
Skilled nursing facility	100%[9]	50%
Emergency services Emergency room (copay waived if admitted)	100%[9] facility / $0 physician (ded. waived)	100%[9] facility / $0 physician (ded. waived)
Urgent care	Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[6]	50%
Ambulance services (ground and air)	100%[9]	100%[9]
Mental/Behavioral health / Substance use disorder services[10] Mental/Behavioral health / Substance use disorder services (inpatient)	100%[9]	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $0 (ded. waived) Other than office visit: 100% up to $75	Office visit: 50% Other than office visit: 50%
Home health care services (100 visits/year)	100%[9]	Not covered

(continued)

Bronze 60 EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Other services Durable medical equipment	100%[9]	Not covered
Hospice service	$0 (ded. waived)	50%
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$500 single / $1,000 family	Not covered
Prescription drugs[11] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands) Tier II (non-preferred generics and preferred brands) Tier III (non-preferred brands only) Tier IV (Specialty drugs)	100% up to $500 / 30-day script (after Rx ded.)[12]	Not covered
Pediatric dental[13,14] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[13,15] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the policy for terms and conditions of coverage.

[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible 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.

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[6] Visits 1–3 (combined between office visits, specialist office visits, urgent care, prenatal and postnatal visits, and acupuncture): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

[7] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders 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. In addition, 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.

[8] 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.

[9] After the medical deductible has been reached, the member is responsible for 100% of the eligible charges until his or her out-of-pocket maximum limit is met. For in-network benefits, eligible charges are the negotiated rate. For out-of-network emergency room and emergency medical transportation, eligible charges are the allowed charges.

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

[11] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[12] After the pharmacy deductible has been reached, the member will be responsible for 100% of the cost of all Tier 1, 2, 3, and 4 drugs up to a maximum payment of $500 for each prescription of up to a 30-day supply, until the out-of-pocket maximum limit is met.

[13] Pediatric dental and vision are included on all plans.

[14] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[15] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.

Minimum Coverage EnhancedCare PPO

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible[4]	$7,350 single / $14,700 family	$14,700 single / $29,400 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,350 single / $14,700 family	$25,000 single / $50,000 family
Professional services Office visit	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	50%
Teladoc consultation telehealth services[7]	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	Not covered
Specialist consultation	0%	50%
Other practitioner office visit (including medically necessary acupuncture)	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	50%
Preventive care services[8]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	0%	50%
Rehabilitation and habilitation therapy	0%	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	0%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	0%	50%
Skilled nursing facility	0%	50%
Emergency services Emergency room (copay waived if admitted)	0% facility / $0 (ded. waived) physician	0% facility / $0 (ded. waived) physician
Urgent care	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	50%
Ambulance services (ground and air)	0%	0%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder services (inpatient)	0%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6] Other than office visit: 0%	50%
Home health care services (100 visits/year)	0%	Not covered
Other services Durable medical equipment	0%	Not covered
Hospice service	$0	50%

(continued)

Minimum Coverage EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drug calendar year deductible (per insured) *Subject to medical deductible*	Integrated with medical deductible	Not covered
Prescription drugs[10] (up to a 30-day supply obtained through a participating pharmacy) Tier I (most generics and low-cost preferred brands) Tier II (non-preferred generics and preferred brands) Tier III (non-preferred brands only) Tier IV (Specialty drugs)	0%	Not covered
Pediatric dental[11,12] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[11,13] Routine eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0	Not covered

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the policy for terms and conditions of coverage.

Minimum coverage plans are available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this plan.

[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied for in-network providers and $500 is applied for out-of-network providers. Refer to the policy 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 policy for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible 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.

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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

[7] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders 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. In addition, 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.

[8] 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.

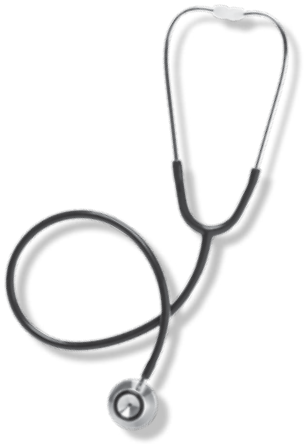
[9] Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[10] 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 policy for complete information about 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 policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The policy is a legal, binding document. If the information in this brochure differs from the information in the policy, the policy 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.myhealthnetca.com.

[11] Pediatric dental and vision are included on all plans.

[12] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services. Dental Benefit Administrative Services is not affiliated with Health Net Life Insurance Company. See the policy for pediatric dental benefit details.

[13] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, LLC. EyeMed Vision Care, LLC is not affiliated with Health Net Life Insurance Company.



Major medical expense coverage

This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care, and prosthetic appliances subject to any deductibles, copayment provisions, or other limitations which may be set forth in the Policy.

Principal benefits and coverages

Please refer to the list below for a summary of each plan's covered services and supplies. Also refer to the Policy you receive after you enroll in a plan. The Policy offers more detailed information about the benefits and coverage included in your health insurance plan.
Note: EnhancedCare PPO insurance plans do not cover health care services outside of the state of California, except for emergency and urgent care.

- Allergy serum
- Allergy testing and treatment
- Ambulance services – ground ambulance transportation and air ambulance transportation
- Ambulatory surgical center
- Bariatric (weight loss) surgery (not covered out-of-network)
- Care for conditions of pregnancy
- Clinical trials
- Corrective footwear to prevent or treat diabetes-related complications
- Diabetic equipment
- Diagnostic imaging (including X-rays) and laboratory procedures
- Habilitation therapy
- Home health care agency services
- Hospice care
- Inpatient hospital services
- Medically necessary implanted lens that replaces the organic eye lens
- Medically necessary reconstructive surgery
- Medically necessary surgically implanted drugs
- Mental health care and chemical dependency benefits
- Outpatient hospital services
- Outpatient infusion therapy
- Organ, tissue and bone marrow transplants
- Patient education (including diabetes education)
- Pediatric dental and vision as specified in the Policy
- Phenylketonuria (PKU)
- Pregnancy and maternity services
- Preventive care services
- Professional services
- Prostheses
- Radiation therapy, chemotherapy and renal dialysis treatment
- Rehabilitation therapy (including physical, speech, occupational, cardiac, and pulmonary therapy)
- Rental or purchase of durable medical equipment
- Self-injectable drugs
- Skilled nursing facility
- Sterilizations for males and females
- Treatment for dental injury, if medically necessary

Reproductive health services

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at 1-800-522-0088 to ensure that you can obtain the health care services that you need.

Cost-sharing

Coverage is subject to deductible(s), coinsurances and copayments. Please consult the Policy for complete details.

Certification (prior authorization of services)

Some services are subject to precertification. Please consult the complete list of services in the Policy.

Exclusions and limitations

The following is a partial list of services that are not generally covered. For complete details about any plan's exclusions and limitations, please see the Policy for complete details.

- Services or supplies that are not medically necessary.
- Cosmetic surgery, except as specified in the Policy.
- Dental services for adults 19 and over, except as specified in the Policy.
- Treatment and services for temporomandibular (jaw) joint disorders (TMJ) (except medically necessary surgical procedures).
- Surgery and related services for the purposes of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are medically necessary.
- Food, dietary, or nutritional supplements, except for formulas and special food products to prevent complications of Phenylketonuria (PKU).
- Vision care for adults ages 19 and older, including certain eye surgeries to replace glasses, except as specified in the Policy.
- Optometric services for adults ages 19 and older, except as specifically stated elsewhere in the Policy.
- Eyeglasses or contact lenses for adults ages 19 and older, except as specified in the Policy.
- Services to reverse voluntary surgically induced infertility.
- Services or supplies that are intended to impregnate a woman are not covered. The following services and supplies are excluded from fertility preservation coverage: gamete or embryo storage; use of frozen gametes or embryos to achieve future conception; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; gestational carriers (surrogates).
- Certain genetic testing.
- Experimental or investigative services.
- Immunizations or inoculations for adults or children for foreign travel or occupational purposes.
- Custodial or domiciliary care.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.

- Any services or supplies furnished by a non-eligible institution, which is other than a legally operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how it is designated. This exclusion does not apply to services required for severe mental illness, serious emotional disturbances of a child, autism or pervasive developmental disorder.
- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate.
- Infertility services.
- Private duty nursing.
- Personal comfort items.
- Orthotics, unless custom made to fit the covered person's body and as specified in the Policy.
- Educational services or nutritional counseling, except as specified in the Policy.
- Hearing aids.
- Obesity-related services except as stated in the Policy.
- Services received before your effective date of coverage.
- Services received after coverage ends.
- Services for which no charge is made to the covered person in the absence of insurance coverage, except services received at a charitable research hospital, which is not operated by a governmental agency.
- Physician self-treatment.
- Services performed by a person who lives in the covered person's home or who is related to the covered person by blood or marriage.
- Conditions caused by the covered person's commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.
- Conditions caused by release of nuclear energy, when government funds are available.
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net insured. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Services and supplies obtained while in a foreign country with the exception of emergency care.
- Home birth, unless criteria for emergency care have been met.
- Reimbursement for services for which the covered person is not legally obligated to pay the provider in the absence of insurance coverage.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the covered person's residence to accommodate the covered person's physical or medical condition, including the installation of elevators; and (b) air purifiers, air conditioners and humidifiers.
- Some disposable supplies for home use, except for diabetic supplies as listed in the Policy.

Some services require precertification from Health Net prior to receiving services. Please refer to your Policy for details about what services and procedures require precertification.

Health Net does not require precertification for dialysis services or maternity care. However, please call the Customer Contact Center at 1-800-522-0088 upon initiation of dialysis services or at the time of the first prenatal visit.

Renewability of this Policy

Subject to the termination provisions discussed in the Policy, coverage will remain in effect for each month premiums are received and accepted by Health Net Life.

Premiums

We may adjust or change your premium. If we change your premium amount, notice will be mailed to you at least 60 days prior to the premium change effective date. Premiums are automatically adjusted for changes in your and your dependent spouse's or registered domestic partner's ages. Premiums may be adjusted when your residence address changes.

Claims-to-premium ratio

Health Net's 2016 ratio of incurred claims to earned premiums after risk adjustment and reinsurance for the Individual & Family PPO and EPO insurance plans was 121.4 percent.

Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at:

Health Net Life Insurance Company
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Online: healthnet.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FLY011026EP00 (11/16)

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711). If you bought coverage through the California marketplace call 1-888-926-4988 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية أو اتصل على مركز الاتصال التجاري في 1-800-522-0088 (TTY: 711). في حال قمت بشراء التغطية من سوق كاليفورنيا، اتصل على الرقم 1-888-926-4988 (TTY: 711) وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من شركة التأمين على الحياة Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc., اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Եթե ապահովագրում եք գնել Կալիֆորնիայի շուկայական հրապարակի միջոցով, զանգահարեք 1-888-926-4988 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088（TTY：711）。如果您是透過加州健康保險交易市場購買承保，請致電 1-888-926-4988（TTY：711）。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi

बिना लागत वाली भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711) पर कॉल करें। यदि आपने कैलिफोर्निया मार्किट प्लैस के माध्यम से कवरेज खरीदा है तो 1-888-926-4988 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company पीपीओ PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc. के एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Kev pab, hu rau peb ntawm tus xov tooj teev nyob rau hauv koj daim ID card los yog hu rau 1-800-522-0088 (TTY: 711). Yog tias koj yuav kev pov hwm ntawm California marketplace hu 1-888-926-4988 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088、(TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイス（保険購入サイト）を通じて保険を購入された方は、1-888-926-4988 (TTY: 711) までお電話ください。さらに援助が必要な場合：Health Net Life Insurance CompanyのPPOまたはEP0保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បើសិនអ្នកបានទិញការធានារ៉ាប់រងតាមរយៈ ទីផ្សារនៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទូរសព្ទទៅលេខ 1-888-926-4988 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO ពីក្រុមហ៊ុនធានារ៉ាប់រងជីវិត Health Net Life Insurance Company សូមទាក់ទងទៅនាយកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net of California, Inc. នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나1-800-522-0088 (TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스를 통해 보험을 구입하셨으면 1-888-926-4988 (TTY: 711)번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo
Saad Bee Áká E’eyeed T’áá Jíík’e. Ata’ halne’ígíí hóló. T’áá hó hazaad k’ehjí naaltsoos hach’į’ wóltah. Shíká a’doowoł nínízingo naaltsoos bee néího’dólzinígíí bikáa’gi béésh bee hane’í bikáá’ áajį’ hodíílnih éí doodaii’ 1-800-522-0088 (TTY: 711). California marketplace hoolyéhíjí béeso ách’ą́ąh naanilí ats’íís baa áháyą́ biniiyé nahínółnii’go éí kojį’ hólne’ 1-888-926-4988 (TTY: 711). Shíká anáá’doowoł jinízingo: PPO éí doodaii’ EPOǫjí Health Net Life Insurance Company wolyéhíjí béeso ách’ą́ąh naa’nil biniiyé hwe’iina’ bik’é’ésti’go éí CA Dept. of Insurance bich’į’ hojilnih 1-800-927-4357. HMO éí doodaii’ HSPǫjí Health Net of California, Inc.ǫjí béeso ách’ą́ąh naa’nil biniiyé hats’íís bik’é’ésti’go éí kojį’ hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند.
برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی
1-800-522-0088 (TTY: 711) تماس بگیرید. اگر پوشش بیمه را از طریق بازارگاه کالیفرنیا خریداری کردید با شماره
1-888-926-4988 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی
Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس
بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی
DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਮਾਰਕਿਟ ਪਲੇਸ ਦੇ ਰਾਹੀਂ ਬੀਮਾ ਕਵਰੇਜ਼ ਖਰੀਦੀ ਹੈ ਤਾਂ 1-888-926-4988 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੋ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ Healh Net of California, Inc. ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика.
Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711). Если свою страховку вы приобрели на едином сайте по продаже медицинских страховок в штате Калифорния, звоните по телефону 1-888-926-4988 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance), телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания DMHC, телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Si adquirió la cobertura a través del mercado de California, llame al 1-888-926-4988 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711). Kung bumili kayo ng pagsakop sa pamamagitan ng California marketplace tawagan ang 1-888-926-4988 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) หากคุณซื้อความคุ้มครองผ่านทาง California marketplace โทร 1-888-926-4988 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711). Nếu quý vị mua khoản bao trả thông qua thị trường California 1-888-926-4988 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.

Health Net Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150

1-877-609-8711 *(English)*
1-877-891-9050 *(Cantonese)*
1-877-339-8596 *(Korean)*
1-877-891-9053 *(Mandarin)*
1-800-331-1777 *(Spanish)*
1-877-891-9051 *(Tagalog)*
1-877-339-8621 *(Vietnamese)*

Assistance for the hearing and speech impaired
TTY users call 711.

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