Individual & Family PPO Insurance Plans

Available through Health Net

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

Health Net®

Outline of Coverage and Exclusions and Limitations

Plans available in Northern and Central California[1]

Health Net Life Insurance Company 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 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 PPO plans utilize the PureCare One provider network. Offered in Contra Costa, Marin, Merced, Napa, Orange, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and parts of Kern, Los Angeles, Riverside, and San Bernardino counties.

Health Net Platinum 90 PPO – C4Q

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible	None	None
Out-of-pocket maximum[4]	$4,000 single / $8,000 family	$8,000 single / $16,000 family
Professional services Office visit	$20	50%
Specialist consultation	$40	50%
Preventive care services[5]	$0	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$40 / $20	50%
Imaging (CT/PET scans, MRIs)	10%	50%
Rehabilitation and habilitation therapy	$20	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 / 10% physician	$150 facility / 10% physician
Urgent care	$40	50%
Ambulance services (ground and air)	$150	$150
Mental/Behavioral health / Substance use disorder services Mental/Behavioral health / Substance use disorder services (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $20 Other than office visit: 0%	50%
Home health care services (100 visits/year, in- and out-of-network combined)	10%	50%
Other services Durable medical equipment	10%	Not covered
Acupuncture (medically necessary)	$20	Not covered

(continued)

Health Net Platinum 90 PPO – C4Q *(continued)*

Benefit description	Insured person(s) responsibility	
Chiropractic services	Not covered	Not covered
Prescription drug coverage Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)[6] 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/script	Not covered
Pediatric dental[7,8] Diagnostic and preventive services	$0	0%
Pediatric vision[7,9] Routine eye exam	$0	Not covered
Glasses	1 pair per year	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. 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.

[5] 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 on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6] 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 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 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.healthnet.com.

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

[8] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Health Net Gold 80 PPO – C4P

Benefit description	Insured person(s) responsibility	
Unlimited lifetime maximum	In-network[1,2]	Out-of-network[1,3]
Plan maximums Calendar year deductible	None	None
Out-of-pocket maximum[4]	$6,200 single / $12,400 family	$12,400 single / $24,800 family
Professional services Office visit	$35	50%
Specialist consultation	$55	50%
Preventive care services[5]	$0	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$50 / $35	50%
Imaging (CT/PET scans, MRIs)	20%	50%
Rehabilitation and habilitation therapy	$30	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)	$250 facility / 20% physician	$250 facility / 20% physician
Urgent care	$60	50%
Ambulance services (ground and air)	$250	$250
Mental/Behavioral health / Substance use disorder services Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $35 Other than office visit: 0%	50%
Home health care services (100 visits/year, in- and out-of-network combined)	20%	50%
Other services Durable medical equipment	20%	Not covered
Acupuncture (medically necessary)	$35	Not covered
Chiropractic services	Not covered	Not covered

(continued)

Health Net Gold 80 PPO – C4P *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drug coverage Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)[6]		
Tier I (most generics and low-cost preferred brands)	$15	Not covered
Tier II (non-preferred generics and preferred brands)	$50	Not covered
Tier III (non-preferred brands only)	$70	Not covered
Tier IV (Specialty drugs)	20% up to $250/script	Not covered
Pediatric dental[7,8] Diagnostic and preventive services ($60 deductible applies)	$0	0%
Pediatric vision[7,9] Routine eye exam	$0	Not covered
Glasses	1 pair per year	Not covered

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[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. 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.

[5] 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 on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6] 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 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 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.healthnet.com.

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

[8] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Health Net Silver 70 PPO – C4R

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]	$2,250 single / $4,500 family	$4,500 single / $9,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$6,250 single / $12,500 family	$12,500 single / $25,000 family
Professional services Office visit	$45 (ded waived)	50%
Specialist consultation	$70 (ded waived)	50%
Preventive care services[6]	$0 (ded waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	$65 (ded waived) / $35 (ded waived)	50%
Imaging (CT/PET scans, MRIs)	$250 (ded waived)	50%
Rehabilitation and habilitation therapy	$45 (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)	$250 facility / $50 physician	$250 facility / $50 physician
Urgent care	$90 (ded waived)	50%
Ambulance services (ground and air)	$250	$250
Mental/Behavioral health / Substance use disorder services Mental/Behavioral health / Substance use disorder services (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $45 (ded waived) Other than office visit: $0 (ded waived)	50%
Home health care services (100 visits/year, in- and out-of-network combined)	$45 (ded waived)	50%

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Health Net Silver 70 PPO – C4R *(continued)*

Benefit description	Insured person(s) responsibility	
Other services Durable medical equipment	20% (ded waived)	Not covered
Acupuncture (medically necessary)	$45 (ded waived)	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage Prescription drug calendar year deductible	$250 single / $500 family	Not covered
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)[7] Tier I (most generics and low-cost preferred brands)	$15 (Rx ded waived)	Not covered
Tier II (non-preferred generics and preferred brands)	$50	Not covered
Tier III (non-preferred brands only)	$75	Not covered
Tier IV (Specialty drugs)	20% up to $250/script (after Rx ded)	Not covered
Pediatric dental[8,9] Diagnostic and preventive services	$0 (ded waived)	$0 (ded waived)
Pediatric vision[8,10] Routine eye exam	$0 (ded waived)	Not covered
Glasses	1 pair per year	Not covered

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[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. 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.

[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 on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[7] 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 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 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.healthnet.com.

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

[9] The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[10] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Health Net Bronze 60 PPO – C4M

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]	$6,000 single / $12,000 family	$13,000 single / $26,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$6,500 single / $13,000 family	$13,000 single / $26,000 family
Professional services Office visit	Visits 1–3: $70 (ded waived) / Visits 4+: $70 (ded applies)[6]	50%
Specialist consultation	Visits 1–3: $90 (ded waived) / Visits 4+: $90 (ded applies)	50%
Preventive care services[7]	$0 (ded waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	100% (ded applies) / $40 (ded waived)	100%
Rehabilitation and habilitation therapy	70% (ded waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	100%	100%
Outpatient surgery (hospital or outpatient surgery center charges only)	100%	100%
Skilled nursing facility	100%	100%
Emergency services Emergency room (copay waived if admitted)	100%	100%
Urgent care	Visits 1–3: $120 (ded waived) / Visits 4+: $120 (ded applies)	50%
Ambulance services (ground and air)	100%	100%
Mental/Behavioral health / Substance use disorder services Mental/Behavioral health / Substance use disorder services (inpatient)	100%	100%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: $70 (ded waived) Other than office visit: $0 (ded waived)	50%

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Health Net Bronze 60 PPO – C4M *(continued)*

Benefit description	Insured person(s) responsibility	
Home health care services (100 visits/year, in- and out-of-network combined)	100%	100%
Other services Durable medical equipment	100%	Not covered
Acupuncture (medically necessary)	Visits 1–3: $70 (ded waived) / Visits 4+: $70 (ded applies)[6]	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage Prescription drug calendar year deductible	$500 single / $1,000 family	Not covered
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)[8] Tier I (most generics and low-cost preferred brands)	100% up to $500/script (after Rx ded)	Not covered
Tier II (non-preferred generics and preferred brands)	100% up to $500/script (after Rx ded)	Not covered
Tier III (non-preferred brands only)	100% up to $500/script (after Rx ded)	Not covered
Tier IV (Specialty drugs)	100% up to $500/script (after Rx ded)	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	0%	0%
Pediatric vision[9,11] Routine eye exam	0%	Not covered
Glasses	1 pair per year	Not covered

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[1] Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. 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.

[6] Visits 1–3 (combined between office visits, specialist 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] 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 on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these 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 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 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.healthnet.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 Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[11] The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Health Net Minimum Coverage PPO – C4N

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]	$6,850 single / $13,700 family	$13,700 single / $27,400 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$6,850 single / $13,700 family	$13,700 single / $27,400 family
Professional services Office visit	Visits 1–3: 0% (ded waived) / Visits 4+: 0% (ded applies)[6]	0%
Specialist consultation	0%	0%
Preventive care services[7]	$0 (ded waived)	Not covered
X-ray and diagnostic imaging	0%	0%
Rehabilitation and habilitation therapy	0%	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	0%	0%
Outpatient surgery (hospital or outpatient surgery center charges only)	0%	0%
Skilled nursing facility	0%	0%
Emergency services Emergency room (copay waived if admitted)	0%	0%
Urgent care	Visits 1–3: 0% (ded waived) / Visits 4+: 0% (ded applies)	50%
Ambulance services (ground and air)	0%	0%
Mental/Behavioral health / Substance use disorder services Mental/Behavioral health / Substance use disorder services (inpatient)	0%	0%
Mental/Behavioral health / Substance use disorder services (outpatient)	0%	0%
Home health care services (100 visits/year, in- and out-of-network combined)	0%	0%

Benefit description	Insured person(s) responsibility	
Other services Durable medical equipment	0%	Not covered
Acupuncture (medically necessary)	Visits 1–3: 0% (ded waived) / Visits 4+: 0% (ded applies)[6]	Not covered
Chiropractic services	Not covered	Not covered
Prescription drug coverage Brand-name calendar year deductible	Integrated with medical deductible	Not covered
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)[8] Tier I (most generics and low-cost preferred brands)	0%	Not covered
Tier II (non-preferred generics and preferred brands)	0%	Not covered
Tier III (non-preferred brands only)	0%	Not covered
Tier IV (Specialty drugs)	0%	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	$0 (ded waived)	$0 (ded waived)
Pediatric vision[9,11] Routine eye exam	$0 (ded waived)	Not covered
Glasses	1 pair per year	Not covered

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Catastrophic 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.

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[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.

[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] 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 on 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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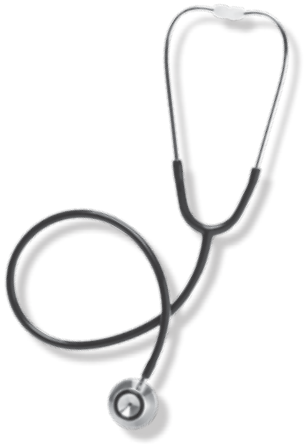

Major medical expense coverage

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.

- 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 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 Life's Customer Contact Center at 1-888-926-4988 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.
- Any amounts in excess of the maximum amounts specified in the Policy.
- 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 age 19 and older, including certain eye surgeries to replace glasses, except as specified in the Policy.
- Optometric services or eye exercises for adults age 19 and older, except as specifically stated elsewhere in the Policy.
- Eyeglasses or contact lenses for adults age 19 and older, except as specified in the Policy.
- Sex changes.
- 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.
- Routine physical exams, except for preventive care services (e.g., physical exam for insurance, licensing, employment, school, or camp). Any physical, vision or hearing exams, which are not related to a diagnosis or treatment of illness or injury, except as specifically stated in the Policy.

- Immunizations or inoculations for adults or children for foreign travel or occupational purposes.
- Services not related to a covered illness or injury. However, treatment of complications arising from non-covered services, such as complications due to non-covered cosmetic surgery, is covered.
- Custodial or domiciliary care.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility, primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- 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.
- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate.
- Infertility services.
- Private duty nursing.
- Over-the-counter medical supplies and medications, except as specified in the Policy.
- 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.
- Any services received by Medicare benefits without payment of additional premium.
- 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.
- Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as stated in the Policy.

- 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; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- 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 Life does not require precertification for dialysis services or maternity care. However, please call the Customer Contact Center at 1-888-926-4988 upon initiation of dialysis services or at the time of the first prenatal visit.

Precertification is also not required for behavioral health treatment for autism. However, please provide Health Net Life with documentation that a licensed physician or licensed psychologist has established the diagnosis of autism. In addition, the qualified autism service provider must submit the initial treatment plan to Health Net Life. Please refer to your Policy for details.

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 Life's 2014 ratio of incurred claims to earned premiums after risk adjustment and reinsurance for the Individual & Family PPO and EPO insurance plans was 82.1 percent. This ratio of incurred claims to earned premiums calculation differs from the medical loss ratio calculation established under the Affordable Care Act.

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
1-800-995-0852

www.healthnet.com

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