**Bronze 60 EnhancedCare PPO Plan Overview**

**Your Provider Network**

The Bronze 60 EnhancedCare PPO health plan utilizes the EnhancedCare PPO provider network for covered benefits and services. Please make sure you use providers (doctors, hospitals, etc.) in the EnhancedCare PPO provider network. EnhancedCare PPO is available through Covered CA in Los Angeles, Orange, Sacramento, San Diego and Yolo counties, and parts of Placer, Riverside and San Bernardino counties.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The policy and Schedule of Benefits should be consulted for a detailed description of coverage benefits and limitations. The policy is a legal binding document. If the information in this brochure differs from the information in the policy, the policy controls.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net’s cost for the service or supply and are agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received.

<table>
<thead>
<tr>
<th>Benefit description</th>
<th>In-network²,³</th>
<th>Out-of-network²,⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Plan maximums</strong></td>
<td></td>
<td></td>
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<tr>
<td>Calendar year deductible⁵</td>
<td>$6,300 single/ $12,600 family</td>
<td>$12,600 single / $25,200 family</td>
</tr>
<tr>
<td>Out-of-pocket maximum (includes calendar year deductible)⁶</td>
<td>$7,550 single/ $15,100 family</td>
<td>$25,000 single / $50,000 family</td>
</tr>
<tr>
<td><strong>Professional services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)⁷ 50%</td>
<td></td>
</tr>
<tr>
<td>Teladoc consultation telehealth services⁸</td>
<td>$0 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist consultation</td>
<td>Visits 1–3: $105 (ded. waived) / Visits 4+: $105 (ded. applies)⁷ 50%</td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit (including medically necessary acupuncture)</td>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)⁷</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive care services⁹</td>
<td>$0 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>X-ray and diagnostic imaging</td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td>Laboratory procedures</td>
<td>$40 (deductible waived) 50%</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation and habilitation therapy</td>
<td>$75 (deductible waived) Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital facility services (includes maternity)</td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery (hospital or outpatient surgery center charges only)</td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room (copayment waived if admitted)</td>
<td>100%¹⁰ facility (ded. applies) / $0 physician (ded. waived) 100%¹⁰ facility (ded. applies) / $0 physician (ded. waived)</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)⁷ 50%</td>
<td></td>
</tr>
<tr>
<td>Ambulance services (ground and air)</td>
<td>100%¹⁰ 100%¹⁰</td>
<td></td>
</tr>
<tr>
<td><strong>Mental/Behavioral health / Substance use disorder services¹¹</strong></td>
<td>100%¹⁰ 50%</td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral health / Substance use disorder (inpatient)</td>
<td>Office visit: $0 (ded. waived) Other than office visit: 100% up to $75</td>
<td>Office visit: 50% Other than office visit: 50%</td>
</tr>
<tr>
<td>Mental/Behavioral health / Substance use disorder (outpatient)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
**Benefit description** | **Insured person(s) responsibility**
--- | ---
**Home health care services (100 visits/year)** | 100%<sup>10</sup> | Not covered
**Other services**
Durable medical equipment | 100%<sup>10</sup> | Not covered
Hospice service | $0 (deductible waived) | 50%
**Prescription drug coverage**
Prescription drug calendar year deductible (per insured) | $500 single / $1,000 family | Not covered
**Prescription drugs**
(up to a 30-day supply obtained through a participating pharmacy)
Tier 1 (most generics and low-cost preferred brands) | 100% up to $500 / 30-day script (after Rx deductible)<sup>13</sup> | Not covered
Tier 2 (non-preferred generics and preferred brands)
Tier 3 (non-preferred brands only)
Tier 4 (Specialty drugs)
**Pediatric dental**<sup>14,15</sup>
Diagnostic and preventive services | $0 (deductible waived) | Not covered
**Pediatric vision**<sup>14,16</sup>
Eye exam | $0 (deductible waived) | Not covered
Glasses | 1 pair per year – $0 (deductible 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.**

<sup>1</sup>In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost-sharing plan variation (because his or her expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost-sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

<sup>2</sup>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.

<sup>3</sup>Insured pays coinsurance based on the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

<sup>4</sup>Please refer to the policy for out-of-network reimbursement methodology.

<sup>5</sup>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.

<sup>6</sup>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.

<sup>7</sup>Visit 1–3 (combined between non-preventive primary care office visits, specialist office visits, urgent care, and other practitioner [non-physician provider] office visits, including acupuncturists): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

<sup>8</sup>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.

<sup>9</sup>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.

<sup>10</sup>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 and are subject to the in-network deductible and accrue to the in-network out-of-pocket maximum.

<sup>11</sup>Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

<sup>12</sup>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. Tier 1, 2, and 3 prescription drugs filled through mail order (up to a 90-day supply) require three times the level of copayment. For details regarding a specific drug, go to www.myhealthnetca.com.

<sup>13</sup>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.

<sup>14</sup>Pediatric dental and vision is included up to the last day of the month in which the insured turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

<sup>15</sup>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.

<sup>16</sup>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.
Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, 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:
Individual & Family Plan (IFP) Covered Persons On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Covered Persons Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net’s Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net’s Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:
Health Net Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348
Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, 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).

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, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Net’s Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكنك أن تتوفر لك مترجم ملزم. يمكنك أن تقرأ لك الوثائق بابتك. للحصول على المساعدة، يرجى الاتصال بمركز خدمة العملاء المعني بطلبك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في حدد الالق. فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم Health Net (TTY: 711) 1-800-522-0088 (TTY: 711) 1-877-609-8711

Armenian

Chinese
免费语言服务。您可使用口譯員服務。您可請人將文件唸給您並請我們將某些文件翻譯成您的語言寄給您。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（聽障專線：711）。

Hindi
विभिन्न भाषाओं में सेवाएं. आपके द्वारा प्राप्त कर सकते हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं। आपके कस्टमर कार्ड के साथ हैं।

Hmong

Japanese
無料の言語サービスを提供しております。通訳者をご利用いただけます。日本語で文書をお読みすることは可能です。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・家族向けプラン（IFP）の申込者の方は、1-877-609-8711（TTY: 711）までお電話ください。
Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, sí tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711).

Tagalog

Thai
ไม่มีค่าบริการสำหรับสมาชิก คุณสามารถใช้ฟรี คุณสามารถให้ยืมเอกสารให้พันธมิตรของคุณได้ หากต้องการความช่วยเหลือ หรือคุณมีปัญหาว่าจะทำยังไง โปรดโทรมาเพื่อขอคุณยืมเอกสารฟรี คุณสามารถติดต่อสำนักงานของ Health Net ที่หมายเลข 1-800-522-0088 (TTY: 711) หรือสมัครแผนประกันครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (TTY: 711)

Vietnamese

CA Commercial On and Off-Exchange Member Notice of Language Assistance
FLY017550EH00 (12/17)