**Plan Overview**

The Silver 94 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 is 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>Insured person(s) responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network</td>
</tr>
<tr>
<td><strong>Plan maximums</strong></td>
<td></td>
</tr>
<tr>
<td>Calendar year deductible</td>
<td>$75 single / $150 family</td>
</tr>
<tr>
<td>Out-of-pocket maximum (includes calendar year deductible)</td>
<td>$1,000 single / $2,000 family</td>
</tr>
<tr>
<td><strong>Professional services</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit</td>
<td>$5 (deductible waived) / 50%</td>
</tr>
<tr>
<td>Teladoc consultation</td>
<td>$0 (deductible waived) / Not covered</td>
</tr>
<tr>
<td>Specialist consultation</td>
<td>$8 (deductible waived) / 50%</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$5 (deductible waived) / Not covered</td>
</tr>
<tr>
<td>Preventive care services</td>
<td>$0 (deductible waived) / Not covered</td>
</tr>
<tr>
<td>X-ray and diagnostic imaging</td>
<td>$8 (deductible waived) / 50%</td>
</tr>
<tr>
<td>Laboratory procedures</td>
<td>$8 (deductible waived) / 50%</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 (deductible waived) / 50%</td>
</tr>
<tr>
<td>Rehabilitation and habilitation therapy</td>
<td>$5 (deductible waived) / Not covered</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital facility services (includes maternity)</td>
<td>10% facility / 10% physician (ded. waived) / 50%</td>
</tr>
<tr>
<td>Outpatient surgery (hospital or outpatient surgery center charges only)</td>
<td>10% (deductible waived) / 50%</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>10% / 50%</td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room (copayment waived if admitted)</td>
<td>$50 facility (ded. waived) / $0 physician (ded. waived) / $50 facility (ded. applies) / $0 physician (ded. waived)</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$5 (deductible waived) / 50%</td>
</tr>
</tbody>
</table>
| Ambulance services (ground and air) | $30 /

(continued)
**Benefit description** | **Insured person(s) responsibility**
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Mental/Behavioral health / Substance use disorder (outpatient) | **In-network**<sup>2,3</sup> | **Out-of-network**<sup>2,4</sup>
Office visit: $0 (deductible waived) Other than office visit: $0 (deductible waived) | Office visit: 50% Other than office visit: 50%

Home health care services (100 visits/year) | $3 (deductible waived) | Not covered

Other services | 10% (deductible waived) | Not covered
Durable medical equipment | |

Hospice | $0 (deductible waived) | 50%

**Prescription drug coverage**

Prescription drugs<sup>11</sup> (up to a 30-day supply obtained through a participating pharmacy) |  |

<table>
<thead>
<tr>
<th>Tier</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$3 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>2</td>
<td>$10 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>3</td>
<td>$15 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>4</td>
<td>10% up to $150 / 30-day script (deductible waived)</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Pediatric dental<sup>12,13</sup> Diagnostic and preventive services | $0 (deductible waived) | Not covered

Pediatric vision<sup>12,14</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.

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<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.

<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. Please refer to the policy for out-of-network reimbursement methodology.

<sup>4</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>5</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>6</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. Telhealth 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>7</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>8</sup>Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

<sup>9</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>10</sup>Pediatric dental and vision are 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>11</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>12</sup>The pediatric vision benefits services 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

Armenian

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽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，雇員團保計劃的申請人請撥打 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
विशेष भाषा सेवाएं। आप एक दुर्मुखिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़ा सकते हैं। ब्रेक के लिए, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोजक सामूहिक आयोजक कृपया हेल्थ नेट के कमांडर संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैज़िली एवं (आईएक्सपी) आयोजक कृपया 1-877-609-8711 (TTY: 711) पर कॉल करें।

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も可能です。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, si 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
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้สันทนาได้ คุณสามารถให้ข้อมูลเอกสารเพื่อพิจารณาการที่ต้องการความช่วยเหลือ และคุณมีบริการประจำ จะได้รับการดำเนินการตามสัญญาที่กำหนด รู้สึกว่าสุขใจที่ได้รับการช่วยเหลือจาก Health Net ที่หมายเลข 1-800-522-0088 (โปรด TTY: 711) ผู้มีสิทธิ์แผนสุขภาพและครอบครัว (Individual & Family Plan: IFP) โปรด TTY: 1-877-609-8711 (โปรด TTY: 711)

Vietnamese

CA Commercial On and Off-Exchange Member Notice of Language Assistance

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