## Benefit description

<table>
<thead>
<tr>
<th>Benefit description</th>
<th>Insured person(s) responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan maximums</strong></td>
<td></td>
</tr>
<tr>
<td>Calendar year deductible[^4]</td>
<td>$6,300 single / $12,600 family</td>
</tr>
<tr>
<td>Out-of-pocket maximum (includes calendar year deductible)[^5]</td>
<td>$7,550 single / $15,100 family</td>
</tr>
<tr>
<td><strong>Professional services</strong></td>
<td></td>
</tr>
<tr>
<td>Office visit copay</td>
<td></td>
</tr>
<tr>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[^6]</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist visit</td>
<td></td>
</tr>
<tr>
<td>Visits 1–3: $105 (ded. waived) / Visits 4+: $105 (ded. applies)[^6]</td>
<td>50%</td>
</tr>
<tr>
<td>Other practitioner office visit (including medically necessary acupuncture)</td>
<td></td>
</tr>
<tr>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[^6]</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preventive care services[^7]</td>
<td></td>
</tr>
<tr>
<td>$0 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td>X-ray and diagnostic imaging</td>
<td>100%[^8]</td>
</tr>
<tr>
<td>Laboratory procedures</td>
<td>50%</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>100%[^8]</td>
</tr>
<tr>
<td>Rehabilitation and habilitation therapy</td>
<td>50%</td>
</tr>
<tr>
<td>$75 (deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery (hospital or outpatient surgery center charges only)</td>
<td>100%[^8]</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital facility services (includes maternity)</td>
<td>100%[^8]</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Emergency services</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency room (copayment waived if admitted)</td>
<td>100%[^8] facility / $0 physician (deductible waived)</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td></td>
</tr>
<tr>
<td>Visits 1–3: $75 (ded. waived) / Visits 4+: $75 (ded. applies)[^6]</td>
<td>50%</td>
</tr>
<tr>
<td>Ambulance services (ground and air)</td>
<td>100%[^8]</td>
</tr>
<tr>
<td><strong>Mental/Behavioral health / Substance use disorder services[^9]</strong></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral health / Substance use disorder (inpatient)</td>
<td>100%[^8]</td>
</tr>
<tr>
<td>Mental/Behavioral health / Substance use disorder (outpatient)</td>
<td>Office visit: $0 (deductible waived)</td>
</tr>
<tr>
<td><strong>Home health care services (100 visits/year)</strong></td>
<td>100%[^8]</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

[^1]: This table 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.

[^2]: Fixed dollar amounts are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

[^3]: Not covered

[^4]: Calendar year deductible

[^5]: Out-of-pocket maximum (includes calendar year deductible)

[^6]: Office visit copay

[^7]: Preventive care services

[^8]: X-ray and diagnostic imaging

[^9]: Laboratory procedures

[^10]: Imaging (CT/PET scans, MRIs)

[^11]: Rehabilitation and habilitation therapy

[^12]: Other practitioner office visit (including medically necessary acupuncture)

[^13]: Outpatient services

[^14]: Inpatient hospital facility services (includes maternity)

[^15]: Skilled nursing facility

[^16]: Emergency services

[^17]: Urgent care

[^18]: Ambulance services (ground and air)

[^19]: Mental/Behavioral health / Substance use disorder services

[^20]: Other than office visit: 100%

[^21]: Home health care services (100 visits/year)
**Benefit description** | **Insured person(s) responsibility**
---|---
**Other services** |  |
Durable medical equipment | In-network¹,² 100%³ Not covered
Hospital service | $0 (deductible waived) 50%

**Prescription drug coverage** |  |
Prescription drug calendar year deductible (per insured) | $500 single / $1,000 family Not covered

**Prescription drugs**<sup>10</sup> (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>11</sup> Not covered
Tier 2 (non-preferred generics and preferred brands) |  |
Tier 3 (non-preferred brands only) |  |
Tier 4 (Specialty drugs) |  |

**Pediatric dental**<sup>12,13</sup> |  |
Diagnostic and preventive services | $0 (deductible waived) 10% (deductible waived)

**Pediatric vision**<sup>12,14</sup> |  |
Routine eye exam | $0 (deductible waived) Not covered

Glasses (limitations apply) | In-network¹ (deductible waived) Not covered

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**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.**

¹Certain 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.

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

³Please refer to the policy for out-of-network reimbursement methodology.

⁴Any 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.

⁵Copayments 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.

⁶Visits 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.

⁷Covered 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.

⁸After 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.

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

¹⁰The 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.

¹¹After 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.

¹²Pediatric 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.

¹³The 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.

¹⁴The 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

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。雇主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
बिना शुल्क भाषा सेवाएं। आप एक दुभाबषया प्रास कर सकते हैं। आप दसतावेजों को अपनी भाषा में पढ़वा सकते हैं। यदि आपके पास आईडी कार्ड है तो कुछ ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोजक आयोजक कृपया हेल्थ नेट के कमिश्नर संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) 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。通訳者も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。
Khmer
សេវាភាសាសោយឥតគិតថ្លៃ។ សោកអ្នកអាចទទួលបានអ្នកបកប្បផ្ ទា ល់មាត់។ សោកអ្នកអាចសាដា ប់សគអានឯកសារឱ្យ
សោកអ្នកជាភាសារបេ្មាប់ជំនួយ ្បេិនសបើសោកអ្នកមានប័ណ ្ណេមាគា ល់ខលៃួន េូមសៅទូរេ័ពទាសៅកាន់
សលខរបេ្មាប់ជំនួយ ្បេិនសបើសោកអ្នកមានប័ណ ្ណេមាគា ល់ខលៃួន េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងអតិ្ិជន។ អ្នកោក់ពាក្យេុំគស្មាងជា្ករុមបែលជាបុគគាលិក េូមសៅទូរេ័ពទាសៅ
កាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងរបេ្មាប់ជំនួយ ្បេិនសបើសោកអ្នកមានប័ណ ្ណេមាគា ល់ខលៃួន េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងរបេ្មាប់ជំ
នួយ ្បេិនសបើសោកអ្នកមានប័ណ ្ណេមាគា ល់ខលៃួន េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងរបេ្មាប់ជំ

Korean

Navajo
Doo b33h 7l7n7g00 saad bee h1k1 ada’iiyeed. Ata’ halne’7g77 da [a’ n1 h1d7d0ot’88[. Naaltsoos da t’1á shí shizaad k’ehj7 shich9’ y7dooltah n7n7zingo t’11 n1 1k0dooln77[. !k0t’4ego sh7k1 a’doowo[ n7n7zingo Customer Contact Center hooly4h7j8’ hod77lnih ninaaltsoos nanitingo bee n44ho’dolzin7g77 hodoonihj’ bikáá’. Naaltsoos nehiltsöoso go naanish bá dahakhigií éi koj’ hodilníñ Health Net’s Commercial Contact Center 1-800-522-0088(TTY: 711) ’n h0 d00 ha’1[ch7n7
1-877-609-8711 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزينه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما بگینه شوند. برای دریافت کمک، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس متشورین تامس بگیرید. متقاضیان گروه کارفرما: لطفاً با مرکز تماس 

Panjabi (Punjabi)
ਬਿਨਾਂ ਬਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਰਾ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹਨ। ਤੁਹਾਣੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਣੂੰ ਦੀ ਭਾਸਾ ਪੜ੍ਹ ਿੇ ਸੁਣਾਏ ਜਾ ਸਿਦੇ ਹਨ। ਮਦਦ ਲਈ, ਜੇ ਤੁਹਾਣੂੰ ਿੋਲ ਇੱਕ ਆਈਡੀ ਿਾਰਡ ਹੈ, ਤਾਂ ਬਵਅਿਤੀਗਤ 

Russian
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

Vietnamese