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[4]	None	$5,000 single / $10,000 family
Out-of-pocket maximum[5]	$3,350 single / $6,700 family	$25,000 single / $50,000 family
Professional services Office visit	$15	50%
Teladoc consultation telehealth services[6]	$0	Not covered
Specialist consultation	$30	50%
Other practitioner office visit (including medically necessary acupuncture)	$15	Not covered
Preventive care services[7]	$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[8] 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[9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$5	Not covered
Tier 2 (non-preferred generics and preferred brands)	$15	Not covered
Tier 3 (non-preferred brands only)	$25	Not covered
Tier 4 (Specialty drugs)	10% up to $250 / 30-day script	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0	Not covered
Pediatric vision[10,12] 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 coinsurance based on 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.

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

[10] 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.

[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.

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	None	$5,000 single / $10,000 family
Out-of-pocket maximum[4]	$7,200 single / $14,400 family	$25,000 single / $50,000 family
Professional services Office visit	$30	50%
Teladoc consultation telehealth services[5]	$0	Not covered
Specialist consultation	$55	50%
Other practitioner office visit (including medically necessary acupuncture)	$30	Not covered
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	$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)	$325 facility / $0 physician	$325 facility (ded. waived) / $0 physician (ded. waived)
Urgent care	$30	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 $30	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 1 (most generics and low-cost preferred brands)	$15	Not covered
Tier 2 (non-preferred generics and preferred brands)	$55	Not covered
Tier 3 (non-preferred brands only)	$75	Not covered
Tier 4 (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 coinsurance based on 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 disorder 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. 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.

[9] 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.

[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)	Not covered
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 (ded. waived)	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 1 (most generics and low-cost preferred brands)	$10 (Rx ded. waived)	Not covered
Tier 2 (non-preferred generics and preferred brands)	$50 (after Rx ded.)	Not covered
Tier 3 (non-preferred brands only)	$85 (after Rx ded.)	Not covered
Tier 4 (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

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 coinsurance based on 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.

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

[10] 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.

[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 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]	$7,550 single / $15,100 family	$25,000 single / $50,000 family
Professional services Office visit	$40 (ded. waived)	50%
Teladoc consultation telehealth services[6]	$0 (ded. waived)	Not covered
Specialist consultation	$80 (ded. waived)	50%
Other practitioner office visit (including medically necessary acupuncture)	$40 (ded. waived)	Not covered
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	$40 (ded. waived)	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	20% facility / 20% physician (ded. waived)[8]	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	$40 (ded. waived)	50%
Ambulance services (ground and air)	$255	$255
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder services (inpatient)	20% facility / 20% physician (ded. waived)[8]	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)	$200 single / $400 family	Not covered
Prescription drugs[10] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$15 (after Rx ded.)	Not covered
Tier 2 (non-preferred generics and preferred brands)	$55 (after Rx ded.)	Not covered
Tier 3 (non-preferred brands only)	$80 (after Rx ded.)	Not covered
Tier 4 (Specialty drugs)	20% up to $250 / 30-day script (after Rx ded.)	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 (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 coinsurance based on 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 disorder 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] If a hospital does not bill charges for inpatient professional services separately from the inpatient facility fee, the deductible will apply.

[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. 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.

[11] 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.

[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.

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)	Not covered
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 1 (most generics and low-cost preferred brands)	$15 (Rx ded. waived)	Not covered
Tier 2 (non-preferred generics and preferred brands)	$55 (after Rx ded.)	Not covered
Tier 3 (non-preferred brands only)	$85 (after Rx ded.)	Not covered
Tier 4 (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 coinsurance based on 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.

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

[10] 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.

[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]	$7,550 single / $15,100 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]	Not covered
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 1 (most generics and low-cost preferred brands) Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only) Tier 4 (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 coinsurance based on 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 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.

[7] Health Net contracts with Teladoc to provide telehealth services for medical, mental disorder 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 and are subject to the in-network deductible and accrue to the in-network out-of-pocket maximum.

[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. 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.

[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 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.

[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.

Bronze 60 HDHP 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]	$6,000 single/ $12,000 family	$12,000 single / $24,000 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$6,650 single/ $13,300 family	$25,000 single / $50,000 family
Professional services Office visit	40%	50%
Teladoc consultation telehealth services[6]	0%	Not covered
Specialist consultation	40%	50%
Other practitioner office visit (including medically necessary acupuncture)	40%	Not covered
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging / Laboratory procedures	40%	50%
Imaging (CT/PET scans, MRIs)	40%	50%
Rehabilitation and habilitation therapy	40%	Not covered
Hospital services Inpatient hospital facility services (includes maternity)	40%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40% facility / 0% physician	40% facility / 0% physician
Urgent care	40%	50%
Ambulance services (ground and air)	40%	40%
Mental/Behavioral health / Substance use disorder services[8] Mental/Behavioral health / Substance use disorder services (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder services (outpatient)	Office visit: 40% (ded. waived) Other than office visit: 40%	Office visit: 50% Other than office visit: 50%
Home health care services (100 visits/year)	40%	Not covered
Other services Durable medical equipment	40%	Not covered
Hospice service	0%	50%
Prescription drug coverage Prescription drug calendar year deductible (per insured)	Integrated with medical deductible	Not covered

Bronze 60 HDHP EnhancedCare PPO *(continued)*

Benefit description	Insured person(s) responsibility	
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands) Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only) Tier 4 (Specialty drugs)	40% up to $500 / 30-day script (after Rx ded.)[10]	Not covered
Pediatric dental[11,12] Diagnostic and preventive services	$0 (deductible waived)	Not covered
Pediatric vision[11,13] Routine eye exam	$0 (deductible 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 coinsurance based on 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 disorder 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. 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.

[10] 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.

[11] 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.

[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.

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]	$7,900 single / $15,800 family	$15,800 single / $31,600 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$7,900 single / $15,800 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]	Not covered
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 1 (most generics and low-cost preferred brands) Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only) Tier 4 (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 primary care office visits, urgent care, and other practitioner [non-physician provider] office visits, including acupuncturists, 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 disorder 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.

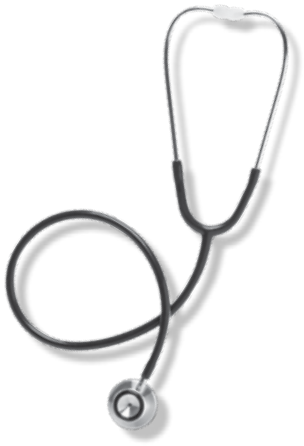
[9] Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[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. 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.

[11] 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.

[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 1-800-839-2172 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 1-800-839-2172 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 2017 ratio of incurred claims to earned premiums after risk adjustment and reinsurance for the Individual & Family PPO and EPO insurance plans was 113.3 percent.

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)
Group Plans through Health Net 1-800-522-0088 (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).

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

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. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 հեռախոսահամարով (TTY՝ 711):

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
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोक्ता सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (TTY: 711).

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
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានប័ណ្ណសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំគម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에 1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우 1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolnííł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá'. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį' hodíílnih Health Net's Commercial Contact Center 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'áłchíní (IFP) báhígíí éí kojį' hojilnih 1-877-609-8711 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس تجاری Health Net به شماره 1-800-522-0088 (TTY:711) تماس بگیرند. متقاضیان طرح فردی و خانوادگی (IFP)* لطفاً با شماره 1-877-609-8711 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲ਼ੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь и у Вас при себе есть карточка участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов, предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону 1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звоните по телефону 1-877-609-8711 (TTY: 711).

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
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nếu quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).

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

FLY017550EH00 (12/17)

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.

www.myhealthnetca.com

BKT023106EO00 (1/19)