Health Net®

Health Net of California, Inc. and
Health Net Life Insurance Company (Health Net)

SMALL BUSINESS GROUP

Small Group Solutions 2021

YOUR GUIDE TO HEALTH NET PLANS FOR 1–100 EMPLOYEES

Effective January 1, 2021

BROKER COMMUNICATIONS

Coverage for every stage of life™

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We look forward to helping you offer the **benefits** your clients **value** at a cost that's good for business.

New For 2021

Health Net is your source for big options for small business, keeping people and companies healthy through every stage of life. We're delivering everything you need to make it easy for you to keep your small group book of business going and growing.

NEW portfolio options with choices to satisfy your clients

Helping employees control costs:

- **Gold 80 PPO 1500/0 plan** paired with Full PPO and EnhancedCare PPO networks
- **HMO Platinum $0 plan** paired with Full Network HMO, WholeCare, SmartCare and Salud HMO y Mas networks
- Low- or no-cost PCP/rehab therapy, lab, x-ray, generic RX cost-sharing with both plans
- HMO Platinum $0 offers no-cost specialist and urgent care

Lean Bronze 60 HDHP PPO 7000/0% plan designed for employers and employees:

- Paired with Full PPO network
- Favorable base buy-up option for employers
- Low-premium spend plan to pair with an HSA account

NEW ancillary bundling brings extra value

Bundle, save and earn with our new ancillary program!

Satisfaction Starts Here

SMALL GROUP SOLUTIONS FOR 2021

Move your business forward – by giving your clients affordable, flexible HMO and PPO options! We offer an array of robust small business-focused solutions. It's easy to help your clients select the right plan and network. And with round-the-clock care options, concierge-style service, wellness programs, and other extras, our plans offer value beyond benefits. The net result is satisfaction – for you and your clients.

Choose from a wide range of cost and coverage options

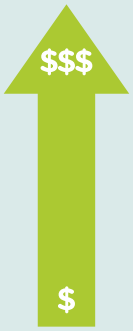
We strive to offer right-size plans that suit both your clients and their balance sheet. Our HMO, HSP and PPO options, each matched with a network of select local care providers, offer favorable rates across the portfolio.

Mix-and-match plans and networks

Employer Groups pick their favorite plan design, then pair it with any of the networks we offer in their region. The plan design stays the same. The process is quick and easy – and we're here to help every step of the way.

HMO

Step 1: Pick your plan design.



- PLATINUM $0
- PLATINUM $10
- PLATINUM $20
- PLATINUM $30
- GOLD $30
- GOLD $35
- GOLD $40
- GOLD $50
- SILVER $50

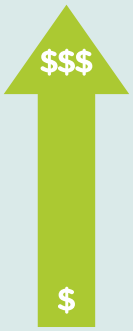
Step 2: Pair your plan with any of the networks we offer in your location.

- FULL NETWORK
- WHOLECARE
- SMARTCARE
- SALUD HMO Y MÁS

There is a mix and match option only available to groups within Los Angeles

PPO

Step 1: Pick your plan design.



- PLATINUM 250/15
- GOLD 0/30
- GOLD 500/20
- GOLD 1000/30
- GOLD 1500/0
- GOLD VALUE
- SILVER 2250/55
- SILVER VALUE
- SILVER HDHP

Step 2: Pair your plan with the network that fits and is available in the group's location.

- FULL PPO NETWORK
- ENHANCEDCARE PPO NETWORK

Enhanced Choice

Health Net's package pairings give small business groups the option to offer multiple plans to their employees. Your clients have their choice of Enhanced Choice A or Enhanced Choice B. Then they can offer any number or combination of plans within the chosen package and available in their region.

See Enhanced Choice in more detail on Page 6

Covered California for Small Business

Health Net Life Insurance Company offers a range of small business group plans through **Covered California™ for Small Business.** For 2021, employers who want to buy via Covered California have their choice of our Full PPO plans listed below:

See Covered California for Small Business on Page 13

Value Beyond Benefits

We want your clients and their employees to get the most from their health plans. That's why we offer programs and services to support their health and wellness.

COVID-19: we're here for the people and businesses of California

We're remaining at the forefront of **COVID-19** industry updates, impacts and activity. As information evolves, we will continue to keep you, our employer groups, and our members, quickly informed, educated, and empowered with choices for health.

Ensure around-the-clock access to care

Our members can always get the care they need, when they need it. All of our plans offer a 24/7 toll-free nurse advice line and access to **MinuteClinic** walk-in clinics across the country. All of our 2021 HMO, HSP and PPO plans offer virtual doctor visits via **Babylon** and also include access to Heal in-home doctor visits for added convenience![1]

Options for extra coverage

Health Net offers add-on dental, vision and life insurance/AD&D plans, and homeopathic health care options, such as chiropractic. With options like these, it's easy for members to build a health plan that suits their unique needs.

Ask our at-your-service team

Our concierge-style customer care team is ready to help. Have a question or concern? We've made it our mission to respond quickly by phone or email with the help you need.

Stay connected on the go

Members can log in to healthnet.com or use our mobile app to access benefit information, wellness programs, identification (ID) cards, and more.

[1]Heal in-home doctor visits on HMO and HSP plans are limited to urgent care services only. PPO plans cover Heal in-home doctor visits related to urgent care, preventive and primary care. Teladoc services available through 12/31/2020.

Wellness resources

Wellness resources like Decision Power®, The Active&Fit Direct™ program, myStrength, and coaching can help members lose weight, quit smoking and manage stress – so that members can live healthy, productive lives.

Decision Power

Whether the focus is on staying fit, making smarter health care decisions or facing a serious diagnosis, Decision Power brings together information, resources and personal support members need to take charge of their health.

The Active&Fit Direct program

Members who enroll in the Active&Fit Direct Program can choose from 11,000+ participating fitness centers nationwide for just $29.99 a month (plus a one-time $29.99 enrollment fee and applicable taxes).

Wellness coaching

Our online health promotion programs use "virtual coaching," personalized weekly tasks and goal-setting tips on a number of topics, such as healthy eating, weight loss, exercise, stress management and ending tobacco use.

The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct is a trademark of ASH and used with permission herein.

Telehealth and Resource Options

Health Net offers additional access to care to ensure members have alternative and convenient means to address their concerns should their primary care physician not be readily available (Babylon, Nurse Advise Line, myStrength, Aunt Bertha and HEAL; services vary by line of business).

Health Net offers Babylon Health – a next-generation telehealth platform with AI powered symptom checker, live chat, and virtual visits with a provider – as our ongoing preferred vendor effective 1/1/2021.

Enhanced Choice Packages

TWO WAYS TO OFFER MULTIPLE PLANS

Health Net invites your clients to be choosy!

Health Net's package pairings give small business groups the option to offer multiple plans to their employees. Your clients have their choice of Enhanced Choice A or Enhanced Choice B. Then they can offer any number or combination of plans within the chosen package and available in their region.

ENHANCED CHOICE PARTICIPATION REQUIREMENTS

Eligible employees + Employee participation minimum:

1–5 + 66%

6–100 + 50%

+

Employer pays:

Minimum of 50% of base plan monthly

or

Minimum of $100 per employee toward the employee-only rate

=

Employees get:

Access to Health Net's

Enhanced Choice portfolio

TWO PACKAGES THAT OFFER MULTIPLE PLANS

Enhanced Choice A

- Full Network HMO
- WholeCare HMO
- SmartCare HMO
- Salud HMO y Más
- CommunityCare HMO
- PureCare HSP
- Full Network PPO

Enhanced Choice B

- Full Network HMO
- WholeCare HMO
- SmartCare HMO
- Salud HMO y Más
- CommunityCare HMO
- PureCare HSP
- Full Network PPO Bronze plans
- EnhancedCare PPO

Network Portfolio At-a-Glance

Your business depends on helping people make the most of their health with coverage that's relevant, local and affordable. Health Net's Small Group equips you with choices to satisfy your clients and power your business.

Product and Network Details

Medical and pharmacy product or network	Description
Full Network HMO	The Full Network HMO is our broadest HMO option spanning 30 counties across California and offering access to over 70,000 physicians (PCPs & Specialists) and over 250 hospitals within the service area. This network is great for employers looking to offer wide provider choice and broad access across California, within a classic HMO structure.
WholeCare HMO Network	The WholeCare HMO network includes a select subset of our Full HMO network to include the most cost-efficient providers without compromise in quality or benefits. This flagship network spans 30 counties across California and offers access to over 37,500 physicians (PCPs/Specialists) and over 200 hospitals within the service area.
SmartCare HMO Network	**A tailored HMO network** available in most of Southern California, as well as Santa Clara and Santa Cruz counties. The network includes over 15,000 physicians (PCPs/Specialists) and over 90 hospitals within the service area.
Salud HMO y Más Network	**A unique HMO tailored network** available in most of Southern California which has been awarded the NCQA Multicultural Health Care Distinction multiple years running. You and your covered dependents can use services in California through our Salud HMO y Más network, or in Mexico through the SIMNSA network. This distinguished network provides access to over 8,500 physicians (PCPs/Specialists) and over 50 hospitals across the Salud service area and is often one of the lowest priced HMOs in Southern California.
CommunityCare HMO Network	A tailored HMO network available in most of Southern California that offers more freedom than our other HMO options. Your primary care physician can refer you to any specialist within the entire CommunityCare HMO network, not just specialists within your physician group. This network also includes plans that have deductibles to allow for greater control of costs and premiums, while providing access to over 12,000 physicians (PCPs/Specialists) and over 75 hospitals within the service area.

Network Portfolio At-a-Glance (continued)

Medical and pharmacy product or network	Description
PureCare HSP Network	PureCare HSP allows for member choice due to a broad 30 county service area and the ability for members to self-refer. Cost containment is achieved through the exclusion of OON benefits and tailoring the network to include high-performing providers and institutions.
Full PPO Network	**PPO insurance plans make it possible** for employees to get the flexibility they want when it comes to a health care provider. Our Full PPO network is one of the largest in California, with a provider network that spans all 58 California counties. Members may access doctors and facilities that are in the network for best cost effectiveness and quality of care, but still have the flexibility to visit providers outside of the network.
EnhancedCare PPO Network	A tailored PPO network specifically designed for employers in Los Angeles. This network includes carefully selected, high-performing providers and facilities throughout Los Angeles county, and is often the lowest priced PPO offered in LA. The network still includes PPO flexibility with out of network care access, in addition to specialized high-touch support through our Health Benefit Navigator Team.
Advanced Choice tailored network pharmacy	**Designed for employer cost control,** Advanced Choice is our tailored pharmacy network. This network is paired with our SmartCare HMO, Salud HMO y Más, CommunityCare HMO, and EnhancedCare PPO plans. Advanced Choice will connect these members with CVS, Walmart, Costco, Safeway, Vons, and many other pharmacies (This network excludes Walgreens).
Chiropractic and Acupuncture Care	**Chiropractic and acupuncture coverage** key features include self-referral services, convenient copayments and coverage of medically necessary X-rays, lab tests and other items (chiropractic only). Providers are easy to access across California via our partner American Specialty Health (ASH) network. All Health Net Small Group ACA plans include Acupuncture coverage. Health Net's HMO and HSP plans include the option to add buy-up Chiropractic coverage while most of our PPO plans include built-in Chiropractic coverage.[2]

For more details, please see **2021 Desktopper**.

[2] Health Net's Standard Covered California PPO plans do not include Chiropractic coverage on or off-exchange: Platinum 90 PPO 0/15 + Child Dental, Gold 80 PPO 350/25 + Child Dental, Silver 70 PPO 2250/50 + Child Dental, Bronze 60 PPO 6300/65 + Child Dental, Bronze 60 HDHP PPO 7000/0% + Child Dental.

Plan Choices by Region

Region		We offer...	With this network
1	**Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba counties**	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
	Nevada County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
2	**Marin, Napa, Solano, and Sonoma counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
3	**Sacramento, Placer, El Dorado, and Yolo counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
4	**San Francisco County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platium, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
5	**Contra Costa County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
6	**Alameda County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
7	**Santa Clara County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

(continued)

Region		We offer...	With this network
8	San Mateo County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
9	Santa Cruz County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
	Monterey and San Benito counties	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
10	Mariposa County	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
	San Joaquin, Stanislaus, Merced, and Tulare counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
11	Fresno, Kings and Madera counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
12	Santa Barbara and Ventura counties	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
	San Luis Obispo County	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
13	Mono, Inyo and Imperial counties	**PPO** Platinum, Gold, Silver, and Bronze	Full Network PPO
14	Kern County	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • Salud HMO y Más
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

(continued)

Region		We offer...	With this network
15	**Los Angeles County: ZIP codes starting with 906–912, 915, 917, 918, 935**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Your choice of: • Full Network PPO • EnhancedCare PPO
16	**Los Angeles County: ZIP codes not in Region 15**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Your choice of: • Full Network PPO • EnhancedCare PPO
17	**San Bernardino and Riverside counties**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
18	**Orange County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO
19	**San Diego County**	**HMO** Platinum, Gold, Silver	Your choice of: • Full Network • WholeCare • SmartCare • Salud HMO y Más
		Silver, Bronze	CommunityCare
		HSP Platinum, Gold, Silver, and Bronze	PureCare
		PPO Platinum, Gold, Silver, and Bronze	Full Network PPO

Health Net PPO Insurance Plans Via Covered California™

PEACE OF MIND FOR EMPLOYEES

Health Net Life Insurance Company offers a range of small business group plans through **Covered California™ for Small Business**. For 2021, employers who want to buy via Covered California have their choice of our Full PPO plans listed below:

- Platinum 90 PPO 0/15 + Child Dental
- Gold 80 PPO 0/30 + Child Dental Alt
- Gold 80 PPO 350/25 + Child Dental
- Gold 80 Value PPO 750/15 + Child Dental Alt
- Silver 70 PPO 2250/50 + Child Dental
- Silver 70 Value PPO 1700/50 + Child Dental Alt
- Silver 70 HDHP PPO 1400/40% + Child Dental Alt
- Bronze 60 PPO 6300/65 + Child Dental
- Bronze 60 HDHP PPO 7000/0% Child Dental

The EnhancedCare PPO plans listed below are also available via Covered California for groups in Los Angeles (regions 15 and 16). The plan designs match the Full Network PPO versions. What differs is the network – EnhancedCare PPO – a tailored PPO network purposely crafted for small employers in Los Angeles. EnhancedCare PPO includes many of the valuable product features enjoyed on the Full PPO network, in addition to specialized high-touch support through our Health Benefit Navigator Team, all at a lower premium.

- EnhancedCare Platinum 90 PPO 250/15 Child Dental Alt
- EnhancedCare Gold 80 PPO 1000/30 Child Dental Alt
- EnhancedCare Silver 70 PPO 2250/55 Child Dental Alt
- EnhancedCare Silver 70 HDHP PPO 1400/40% Child Dental Alt

Small businesses that buy through Covered California may qualify for a tax credit of up to 50% of the business' share of employee premiums. Here's how:

- Employers must have no more than 25 full-time equivalent employees (FTEs).
- Average employee wages must be under $50,000.
- Employers must contribute at least 50% of each employee's premium.

Small business employers can still deduct the rest of their premium costs not covered by the tax credit.

The premium tax credit applies only to small businesses participating in Covered California.

Add Value with Ancillary Benefits

CREATE CUSTOM SOLUTIONS WITH THESE AFFORDABLE OPTIONS

Dental, Vision, Chiropractic, Life, and AD&D.

It's easy to design a well-rounded benefits package with Health Net. We offer a number of options to enhance our medical plans, so that members can design a custom plan that meets their unique health needs.

Please read the following pages for more information on our offerings. For benefit grids and to learn more about our **NEW 2021 multi-product bundling discount program**, please visit our **2021 Ancillary Product Guide**.

Dental plans that make them smile

Health Net offers a choice of HMO and PPO dental plan designs for individual or family coverage, along with access to one of the largest dental networks in California. Health Net Dental HMO and Dental PPO plans include most dental services. Members may purchase any of our dental plans on a standalone basis or they may pair them with a medical plan bought directly through Health Net. Pediatric dental coverage (ages newborn through 18) is included on all medical plans purchased through Health Net.

Dental plan highlights

DENTAL HMO

Health Net Dental HMO (DHMO) plans[3] give members access to an extensive network of providers and the convenience of having a set copayment for many dental services. Two DHMO plans are available – HN Plus 150 and HN Plus 225. DHMO plans include:

- Access to more than 23,000 DHMO providers in California.
- Added cleanings and adult fluoride.
- Material upgrades, such as porcelain and semiprecious or precious metal molar crowns.
- General anesthesia, and cosmetic and elective dentistry – services typically not covered under most other carriers' dental plans.
- Implants.

Health Net DHMO plans may be purchased separately or as a dual choice with Health Net Dental PPO plans.

DENTAL PPO

Health Net offers a range of affordable, flexible Dental PPO plans (DPPO).[4] DPPO plans include:

- Large statewide and national network of Dental PPO providers, which includes more than 46,000 providers in California and over 403,000 providers nationwide.
- Periodontics, endodontics and oral surgery are covered services on the Classic and Essential plans.
- Classic plans reimburse out-of-network benefits at usual, customary and reasonable (UCR)[5] amounts.
- Essential plans reimburse out-of-network benefits on a limited fee schedule.

(continued)

[3]Health Net Dental HMO plans, other than pediatric dental, are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net.

[4]Health Net Dental PPO and indemnity plans, other than pediatric dental, are underwritten by Unimerica Life Insurance Company. Unimerica Life Insurance Company is not affiliated with Health Net.

[5]Usual, Customary and Reasonable (UCR) is the maximum allowable amount for a dental care service, determined by FAIR Health, Inc., on the basis of the fee usually charged by the provider and data obtained by FAIR Health, Inc. regarding fees charged by providers of similar training and experience for the same service within the same geographic area.

- No waiting periods on any of our DPPO plans.
- All Health Net DPPO plans offer pregnant women added cleanings and periodontal maintenance when medically necessary. These services are not subject to the deductible and do not apply to the calendar year maximum.
- Members and dependents receive the full amount of the orthodontia lifetime maximum even if they started treatment under another carrier's dental PPO plan. This applies only to DPPO plans with orthodontia coverage.

Underwriting highlights

- Dual option available – group may select 2 DPPO plans, 2 DHMO plans, or 1 DHMO and 1 DPPO plan. (Please see "Small Business Group Dental and Vision buy-up guidelines" to determine if the group qualifies for dual option.)
- Voluntary DPPO plans without orthodontia are available to groups with at least two enrolled members.
- Voluntary DPPO plans with orthodontia are available to groups of 10 or more enrolled members.

Our vision plans have a clear advantage

Pediatric vision coverage (ages newborn through 18) is included on all medical plans. We also offer adult PPO Vision plans for ages 19 and older. These plans provide the convenience of a large national network, hassle free setup, administrative processing, and:

- A diverse network of independent and retail providers with over 10,500 vision providers in California and over 87,500 vision providers nationwide, including LensCrafters.
- Low copayments.
- Members and dependents can see any provider they choose, either in-network or out-of-network.
- Discounts of 5–15% on LASIK and PRK from U.S. Laser Network.[6]

You can pick from five different full service plans, one materials only plan and one exam only plan.

Chiropractic coverage

Your clients can enhance their HMO or PureCare HSP medical benefits with Health Net's affordable, quality chiropractic coverage. This service is provided through American Specialty Health Plans of California, Inc. (ASH Plans), a wholly owned subsidiary of American Specialty Health, Incorporated (ASH).

Employers can add chiropractic coverage with their purchase of a small business group medical plan. This coverage does not come standalone.[7]

Chiropractic benefits are included with many of our PPO and EnhancedCare PPO plans.[8]

There's no need to buy extra coverage!

- **Platinum 250/15, Gold 0/30, Gold 500/20, Gold 1000/30, Gold 1500/0, Silver 2250/55, and Value plans: $25 copayment per visit, 12 visits per year, no deductible**
- **Silver HDHP plan: $25 copayment per visit, unlimited visits, deductible applies**

Plus! You can pair one of these PPOs with any of our HMO or HSP plan designs whether or not you want to buy chiropractic coverage.

[6]Members receive a 15% discount on the retail price or 5% off the promotional price of LASIK or PRK laser vision correction procedures. LASIK and PRK correction procedures are provided by U.S. Laser Network, owned by LCA-Vision. Members must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.

[7]Chiropractic care is offered by Health Net of California, Inc. for HMO and HSP plans. Chiropractic care is underwritten by Health Net Life Insurance Company for PPO insurance plans. Chiropractic care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[8]Chiropractic services are neither covered nor available for purchase on Health Net's five "Standard" PPO plans: Platinum 0/15, Gold 350/25, Silver 2250/50, Bronze 6300/65, and Bronze HDHP 7000/0%.

Life and AD&D

Many small businesses want an employee benefits package that includes group term life and accidental death & dismemberment (AD&D) insurance with desirable benefit levels. This allows a small business employer to:

- Enhance their benefit package.
- Offer life insurance benefits at economical rates.

One way employers can enhance their benefits package and lower administrative costs is to consolidate health and life insurance carriers. This removes some of the extra administrative costs that come with managing an employee benefits package. Health Net Life Insurance Company underwrites Group Term Life Benefit Insurance, Accidental Death & Dismemberment, and Dependent Life Insurance.

GROUP LIFE PLAN FEATURES

- **Waiver of premium provision** – A life benefit can be extended during a period of total disability under terms specified in the group Certificate of Insurance.[9]
- **Accelerated death benefit** – Provides financial protection to the insured in time of need, while also protecting the interest of the beneficiary. The accelerated benefit is a portion of the basic life insurance amount and is payable in a lump sum.
- **Conversion privilege** – A conversion privilege to whole life insurance is available to certain members whose coverage terminates due to reasons specified in the group policy.

Accidental Death & Dismemberment (AD&D)

These benefits are usually included as part of the group life insurance policy. Health Net Life Insurance Company does not offer AD&D benefits on a standalone basis.

- Benefit is payable as a result of an accidental loss of life or any of the physical losses specified in the group policy.
- The maximum benefit amount is equal to the basic life amount shown in the policy.
- This maximum benefit amount is payable for loss of life. It can also be payable for:
  - Loss of sight in both eyes.
  - Loss of both hands or both feet, or any two or more of these physical losses in the same accident.
- One half of the maximum benefit amount is payable for:
  - Loss of one hand.
  - Loss of one foot.
  - Loss of sight in one eye.

Group Term Life Insurance

LIFE OPTIONS

Option A	$15,000 flat amount for all employees
Option B	$25,000 flat amount for all employees (15–100 employees)
Option C	$50,000 flat amount for all employees (25–100 employees)

[9]Group Term Life, Supplemental Group Term Life and AD&D products are underwritten by Health Net Life Insurance Company, a subsidiary of Health Net, LLC.

HMO Portfolio

HMO Platinum $0

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $0
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$3,000 / $6,000
Professional services[1] Office visit copay	$0
Specialist visit	$0
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$5
Rehabilitation and habilitation therapy	$0
X-ray / Laboratory procedures	$0 / $0
Complex radiology services (MRI, CT, PET)	$250
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$200 / $500
Hospital services Inpatient hospital	$500 per day (4 day max copayment per admission
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$250
Urgent care	$0
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$500 per day (4 day max copayment per admission
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$0
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$0 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

HMO Platinum $10

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $10
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$1,750 / $3,500
Professional services[1] Office visit copay	$10
Specialist visit	$30
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$10
Rehabilitation and habilitation therapy	$10
X-ray / Laboratory procedures	$20 / $20
Complex radiology services (MRI, CT, PET)	$150
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$60 / $150
Hospital services Inpatient hospital	$250 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$150
Urgent care	$30
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$250 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$10
Other services Durable medical equipment	10%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Platinum $20

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $20
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$3,000 / $6,000
Professional services[1] Office visit copay	$20
Specialist visit	$40
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$20
Rehabilitation and habilitation therapy	$20
X-ray / Laboratory procedures	$20 / $20
Complex radiology services (MRI, CT, PET)	$200
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$200 / $500
Hospital services Inpatient hospital	$350 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$200
Urgent care	$40
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$350 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20
Other services Durable medical equipment	20%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Platinum $30

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum $30
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$2,500 / $5,000
Professional services[1] Office visit copay	$30
Specialist visit	$50
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$30
X-ray / Laboratory procedures	$30 / $30
Complex radiology services (MRI, CT, PET)	$250
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$200 / $500
Hospital services Inpatient hospital	$500 per day (4 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$250
Urgent care	$50
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$500 per day (4 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $30 / $50
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $30

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $30
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,000 / $12,000
Professional services[1] Office visit copay	$30
Specialist visit	$50
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$30
X-ray / Laboratory procedures	$40 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$360 / $900
Hospital services Inpatient hospital	$750 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$50
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $35

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $35
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,500 / $13,000
Professional services[1] Office visit copay	$35
Specialist visit	$55
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$35
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$480 / $1,200
Hospital services Inpatient hospital	$750 per day (3 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$55
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$35
Other services Durable medical equipment	30%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $40

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $40
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$6,500 / $13,000
Professional services[1] Office visit copay	$40
Specialist visit	$60
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$40
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$480 / $1,200
Hospital services Inpatient hospital	$750 per day (4 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$60
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (4 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$40
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $70
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Gold $50

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Gold $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$7,000 / $14,000
Professional services[1] Office visit copay	$50
Specialist visit	$70
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$50
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$520 / $1,300
Hospital services Inpatient hospital	$850 per day (5 day max copayment per admission)
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	$300
Urgent care	$70
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$750 per day (5 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$450 / $900
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $50 / $70
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

HMO Silver $50

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Silver $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$7,950 / $15,900
Professional services[1] Office visit copay	$50
Specialist visit	$70
Telehealth services through Babylon[2]	$0
MinuteClinic[3]	$30
Rehabilitation and habilitation therapy	$50
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 50%
Hospital services Inpatient hospital	50%
Skilled nursing facility	$25 per day
Emergency services Emergency room (copay waived if admitted)	50%
Urgent care	$70
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50
Other services Durable medical equipment	50%
Acupuncture (medically necessary)[5]	$10
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$750 / $1,500
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$20 (ded. waived) / 50% / 50%
Tier 4 Specialty drugs[9]	50%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

Salud HMO y Más – SIMNSA network

SIMNSA NETWORK BENEFITS ARE AVAILABLE WITH ANY OF THE SALUD HMO Y MÁS PLANS.

Available only with the Salud HMO y Mas network. The SIMNSA tier benefits are the same regardless of which Salud HMO y Mas plan design is selected.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	SIMNSA[12]
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$1,500 / $4,500[13]
Professional services[1] Office visit copay	$5
Specialist visit	$5
Telehealth services through Babylon[2]	Not covered
MinuteClinic[3]	Not covered
Rehabilitation and habilitation therapy	$5
X-ray / Laboratory procedures	$0 / $0
Complex radiology services (MRI, CT, PET)	$0
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	$0 / $0
Hospital services Inpatient hospital	$0
Skilled nursing facility	$0
Emergency services Emergency room (copay waived if admitted)	$10
Urgent care	$10
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	$0[14]
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$5
Other services Durable medical equipment	$0
Acupuncture (medically necessary)[5]	Not covered
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 / $5 / $5
Tier 4 Specialty drugs[9]	$5
Pediatric dental[10] Diagnostic and preventive services	Not covered
Pediatric vision[11] Routine eye exam	Not covered
Glasses (limitations apply)	Not covered

BKT033351EL00 (1/20)

CommunityCare HMO Portfolio

CommunityCare Silver $1,750/$50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	CommunityCare Silver $50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$1,750 / $3,500
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit copay	$50 (ded. waived)
Babylon consultation telehealth services[2]	$0 (ded. waived)
Specialist visit	$70 (ded. waived)
Rehabilitation and habilitation therapy	$50 (ded. waived)
MinuteClinic[3]	$30 (ded. waived)
X-ray / Laboratory procedures	$50 / $40
Complex radiology services (MRI, CT, PET)	$300
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	$25 per day (ded. waived)
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	$70 (ded. waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	$10 (ded. waived)
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$250 / $500
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

CommunityCare Bronze 60 HMO 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	CommunityCare HMO Silver $20
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$6,300 / $12,600
Out-of-pocket maximum (single / family)	$8,200 / $16,400
Professional services[1] Office visit copay	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Babylon consultation telehealth services[2]	$0 (ded. waived)
Specialist visit	Visits 1-3 $95 (ded. waived) / Visits 4+ $95 (ded. applies)[12]
Rehabilitation and habilitation therapy	$65 (ded.waived)
MinuteClinic[3]	$30 (ded. waived)
X-ray / Laboratory procedures	40% / $40 (ded. waived)
Complex radiology services (MRI, CT, PET)	40%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	40%
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded.waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65 (ded. applies)[12]
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$500 / $1,000
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

PureCare HSP Portfolio

PureCare Platinum 90 HSP 0/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Platinum 90 HSP 0/15
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	$4,500 / $9,000
Professional services[1] Office visit	$15
Specialist visit	$30
Telehealth services through Babylon[2]	$0
Rehabilitation and habilitation therapy	$15
X-ray / Laboratory procedures	$30 / $15
Complex radiology services (MRI, CT, PET)	10%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%
Hospital services Inpatient hospital	10%
Skilled nursing facility	10%
Emergency services Emergency room (copay waived if admitted)	$200
Urgent care	$15
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	10%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15
Other services Durable medical equipment	10%
Acupuncture (medically necessary)[5]	$15
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $25 / $40
Tier 4 Specialty drugs[9]	10%
Pediatric dental[10] Diagnostic and preventive services	$0
Pediatric vision[11] Routine eye exam	$0
Glasses (limitations apply)	$0

BKT033351EL00 (1/20)

PureCare Gold 80 HSP 350/25

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Gold 80 HSP 250/25
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$350 / $700
Out-of-pocket maximum (single / family)	$7,800 / $15,600
Professional services[1] Office visit	$25 (ded. waived)
Specialist visit	$50 (ded. waived)
Telehealth services through Babylon[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$25 (ded. waived)
X-ray / Laboratory procedures	$65 (ded. waived) / $25 (ded. waived)
Complex radiology services (MRI, CT, PET)	20% (ded. waived)
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived)/ 20% (ded. waived)
Hospital services Inpatient hospital	20%
Skilled nursing facility	20%
Emergency services Emergency room (copay waived if admitted)	20%
Urgent care	$25 (ded. waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$25 (ded. waived)
Other services Durable medical equipment	20% (ded. waived)
Acupuncture (medically necessary)[5]	$25 (ded. waived)
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	N/A
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $80
Tier 4 Specialty drugs[9]	20%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

PureCare Silver 70 HSP 2250/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Silver 70 HSP 2250/50
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$2,250 / $4,500
Out-of-pocket maximum (single / family)	$8,200 / $16,400
Professional services[1] Office visit	$50 (ded. waived)
Specialist visit	$85 (ded. waived)
Telehealth services through Babylon[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$50 (ded. waived)
X-ray / Laboratory procedures	$85 (ded. waived) / $50 (ded. waived)
Complex radiology services (MRI, CT, PET)	30%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%
Hospital services Inpatient hospital	30%
Skilled nursing facility	30%
Emergency services Emergency room (copay waived if admitted)	30%
Urgent care	$50 (ded. waived)
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	30%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)
Other services Durable medical equipment	30% (ded. waived)
Acupuncture (medically necessary)[5]	$50 (ded. waived)
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$300 / $600
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$17 (Rx ded. waived) / $70 / $100
Tier 4 Specialty drugs[9]	30%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351EL00 (1/20)

PureCare Bronze 60 HSP 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage* (EOC) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Bronze 60 HSP 6300/65
Unlimited lifetime maximum	✔
Plan maximums Calendar year deductible (single / family)	$6,300 / $12,600
Out-of-pocket maximum (single / family)	$8,200 / $16,400
Professional services[1] Office visit	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Specialist visit	Visits 1–3: $95 (ded. waived) / visits 4+: $95[3]
Telehealth services through Babylon[2]	$0 (ded. waived)
Rehabilitation and habilitation therapy	$65 (ded. waived)
X-ray / Laboratory procedures	40% / $40 (ded. waived)
Complex radiology services (MRI, CT, PET)	40%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%
Hospital services Inpatient hospital	40%
Skilled nursing facility	40%
Emergency services Emergency room (copay waived if admitted)	40%
Urgent care	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Mental/Behavioral health / Substance use disorder services[4] Mental/Behavioral health / Substance use disorder (inpatient)	40%[3]
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded. waived)
Other services Durable medical equipment	40%
Acupuncture (medically necessary)[5]	Visits 1–3: $65 (ded. waived) / visits 4+: $65[3]
Prescription drug coverage[7,8] Prescription drug deductible (single / family)	$500 / $1,000
Prescription drugs Tier 1 / Tier 2 / Tier 3[6] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%
Tier 4 Specialty drugs[9]	40%
Pediatric dental[10] Diagnostic and preventive services	$0 (ded. waived)
Pediatric vision[11] Routine eye exam	$0 (ded. waived)
Glasses (limitations apply)	$0 (ded. waived)

BKT033351ELO0 (1/20)

PPO Portfolio

Platinum 90 PPO 0/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	N/A	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$4,500 / $9,000	$9,000 / $18,000
Professional services Office visit[7]	$15	50%
Specialist visit	$30	50%
Telehealth services through Babylon[8]	$0	Not covered
Rehabilitation and habilitation therapy	$15	50%
X-ray/Laboratory procedures	$30 / $15	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	$200	$200 (ded. waived)
Urgent care	$15	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15	50%
Other services Durable medical equipment	10%	50%
Acupuncture (medically necessary)[11]	$15	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $25 / $40	Not covered
Tier 4 Specialty drugs[15]	10%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Platinum 90 PPO 250/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$250 / $500	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$3,800 / $7,600	$9,000 / $18,000
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	50%
X-ray/Laboratory procedures	$30 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	10%	10%
Urgent care	$30 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	10%	50%
Acupuncture (medically necessary)[11]	$15 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $35 / $60	Not covered
Tier 4 Specialty drugs[15]	10%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 0/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$0	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$30	50%
Specialist visit	$50	50%
Telehealth services through Babylon[8]	$0	Not covered
Rehabilitation and habilitation therapy	$30	50%
X-ray/Laboratory procedures	$40 / $30	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	$50	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$30	50%
Chiropractic care	$25 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 350/25

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$350 / $700	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$25 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$25 (ded. waived)	50%
X-ray/Laboratory procedures	$65 (ded. waived) / $25 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	20% (ded. waived)	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	20% (ded. waived) / 20% (ded. waived)	50% / 50%
Hospital services Inpatient hospital	20%	50%
Skilled nursing facility	20%	50%
Emergency services Emergency room (copay waived if admitted)	20%	20%
Urgent care	$25 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	20%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$25 (ded. waived)	50%
Other services Durable medical equipment	20% (ded. waived)	50%
Acupuncture (medically necessary)[11]	$25 (ded. waived)	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $50 / $80	Not covered
Tier 4 Specialty drugs[15]	20%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 500/20

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$500 / $1,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$20 (ded. waived)	50%
Specialist visit	$40 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$20 (ded. waived)	50%
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$40 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$20 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 1000/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,000 / $2,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$30 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$30 (ded. waived)	50%
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$30 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Gold 80 PPO 1500/0

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,500 / $3,000	$3,000 / $6,000
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$0 (ded. waived)	50%
Specialist visit	$70 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not Covered
Rehabilitation and habilitation therapy	$0 (ded. waived)	50%
X-ray/Laboratory procedures	$0 (ded. waived)	50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40%	50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$70 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$0 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	$0 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$0 (ded. waived) / $50 / $90	Not Covered
Tier 4 Specialty drugs[15]	40%	Not Covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not Covered
Glasses (limitations apply)	$0 (ded. waived)	Not Covered

BKT033351EL00 (1/20)

Gold 80 Value PPO 750/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$750 / $1,500	$2,250 / $4,500
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	50%
X-ray/Laboratory procedures	$25 / $25	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	$250	$250
Urgent care	$30	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	30%	50%
Acupuncture (medically necessary)[11]	$15 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$750 / $1,500 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Silver 70 PPO 2250/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$8,200 / $16,400	$16,400 / $32,800
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$85 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	50%
X-ray/Laboratory procedures	$85 (ded. waived) / $50 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	30% (ded. waived)	50%
Acupuncture (medically necessary)[11]	$50 (ded. waived)	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$17 (ded. waived) / $70 / $100	Not covered
Tier 4 Specialty drugs[15]	30%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Silver 70 PPO 2250/55

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$55 (ded. waived)	50%
Specialist visit	$80 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$55 (ded. waived)	50%
X-ray/Laboratory procedures	$65 (ded. waived) / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$80 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$55 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	$55 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $85	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Silver 70 Value PPO 1700/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,700 / $3,400	$3,400 / $6,800
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$75	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	50%
X-ray/Laboratory procedures	$50 / $40	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$75	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	$50 (ded. waived)	50%
Chiropractic care	$25 (ded. waived) 12 visits max per year	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$1,700 / $3,400 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $100	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Silver 70 HDHP PPO 1400/40%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4,5]	$1,400 / $2,800	$2,800 / $5,600
Out-of-pocket maximum (single / family)[6]	$7,000 / $14,000	$14,000 / $28,000
Professional services Office visit[7]	40%	50%
Specialist visit	40%	50%
Telehealth services through Babylon[8]	$0	Not covered
Rehabilitation and habilitation therapy	40%	50%
X-ray/Laboratory procedures	40% / 40%	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	40%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	40%	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	40%	50%
Chiropractic care	$25 (unlimited visits)	50%
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$1,400 / $2,800 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$19 / $80 / $100	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Bronze 60 PPO 6300/65

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$6,300 / $12,600	$12,600 / $25,200
Out-of-pocket maximum (single / family)[6]	$8,200 / $16,400	$16,400 / $32,800
Professional services Office visit[7]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Specialist visit	Visits 1-3 $95 (ded. waived) / Visits 4+ $95[10]	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$65 (ded. waived)	50%
X-ray/Laboratory procedures	40% / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$65 (ded. waived)	50%
Other services Durable medical equipment	40%	50%
Acupuncture (medically necessary)[11]	Visits 1-3 $65 (ded. waived) / Visits 4+ $65[10]	50%
Chiropractic care	Not covered	Not covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$500 / $1,000 Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	$18 / 40% / 40%	Not covered
Tier 4 Specialty drugs[15]	40%	Not covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[17] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

Bronze 60 HDHP PPO 7000/0%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$7,000 / $14,000	$14,000 / $28,000
Out-of-pocket maximum (single / family)[6]	$7,000 / $14,000	$14,000 / $28,000
Professional services Office visit[7]	0%	0%
Specialist visit	0%	0%
Telehealth services through Babylon[8]	0%	Not Covered
Rehabilitation and habilitation therapy	0%	0%
X-ray/Laboratory procedures	0%	0%
Complex radiology services (MRI, CT, PET)	0%	0%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	0%	0%
Hospital services Inpatient hospital	0%	0%
Skilled nursing facility	0%	0%
Emergency services Emergency room (copay waived if admitted)	0%	0%
Urgent care	0%	0%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	0%	0%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	0%	0%
Other services Durable medical equipment	0%	0%
Acupuncture (medically necessary)[11]	0%	0%
Chiropractic care	Not Covered	Not Covered
Prescription drug coverage[13,14] Prescription drug deductible (single / family)	$7,000 / $14,000 Integrated med/Rx ded. Applies to all tiers	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[12] (up to a 30-day supply obtained through a participating pharmacy)	0% / 0% / 0%	Not Covered
Tier 4 Specialty drugs[15]	0%	Not Covered
Pediatric dental[16] Diagnostic and preventive services	$0 (ded waived)	10% (ded waived)
Pediatric vision[17] Routine eye exam	$0 (ded waived)	Not Covered
Glasses (limitations apply)	$0 (ded waived)	Not Covered

BKT033351EL00 (1/20)

EnhancedCare PPO Portfolio

EnhancedCare Platinum 90 PPO 250/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$250 / $500	$1,000 / $2,000
Out-of-pocket maximum (single / family)[6]	$3,800 / $7,600	$9,000 / $18,000
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	Not covered
X-ray/Laboratory procedures	$30 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	10%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	10% / 10%	50% / 50%
Hospital services Inpatient hospital	10%	50%
Skilled nursing facility	10%	50%
Emergency services Emergency room (copay waived if admitted)	10%	10%
Urgent care	$30 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	10%	Not covered
Acupuncture (medically necessary)[10]	$15 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$10 / $35 / $60	Not covered
Tier 4 Specialty drugs[14]	10%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 0/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$0	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$30	50%
Specialist visit	$50	50%
Telehealth services through Babylon[8]	$0	Not covered
Rehabilitation and habilitation therapy	$30	Not covered
X-ray/Laboratory procedures	$40 / $30	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30% (ded. waived)
Urgent care	$50	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$30	Not covered
Chiropractic care	$25 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	N/A	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0	Not covered
Glasses (limitations apply)	$0	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 500/20

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$500 / $1,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$20 (ded. waived)	50%
Specialist visit	$40 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$20 (ded. waived)	Not covered
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$40 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$20 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$20 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 1000/30

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,000 / $2,000	$2,000 / $4,000
Out-of-pocket maximum (single / family)[6]	$7,600 / $15,200	$15,200 / $30,400
Professional services Office visit[7]	$30 (ded. waived)	50%
Specialist visit	$50 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$30 (ded. waived)	Not covered
X-ray/Laboratory procedures	$40 (ded. waived) / $30 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	30%	30%
Urgent care	$50 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$30 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$30 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$250 / $500 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 PPO 1500/0

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,500 / $3,000	$3,000 / $6,000
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$0 (ded. waived)	50%
Specialist visit	$70 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not Covered
Rehabilitation and habilitation therapy	$0 (ded. waived)	Not Covered
X-ray/Laboratory procedures	$0 (ded. waived)	50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40%	50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$70 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$0 (ded. waived)	50%
Other services Durable medical equipment	40%	Not Covered
Acupuncture (medically necessary)[10]	$0 (ded. waived)	Not Covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not Covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not Covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$0 (ded. waived) / $50 / $90	Not Covered
Tier 4 Specialty drugs[14]	40%	Not Covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not Covered
Glasses (limitations apply)	$0 (ded. waived)	Not Covered

BKT033351EL00 (1/20)

EnhancedCare Gold 80 Value PPO 750/15

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$750 / $1,500	$2,250 / $4,500
Out-of-pocket maximum (single / family)[6]	$7,800 / $15,600	$15,600 / $31,200
Professional services Office visit[7]	$15 (ded. waived)	50%
Specialist visit	$30	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$15 (ded. waived)	Not covered
X-ray/Laboratory procedures	$25 / $25	50% / 50%
Complex radiology services (MRI, CT, PET)	30%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	30% / 30%	50% / 50%
Hospital services Inpatient hospital	30%	50%
Skilled nursing facility	30%	50%
Emergency services Emergency room (copay waived if admitted)	$250	$250
Urgent care	$30	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$15 (ded. waived)	50%
Other services Durable medical equipment	30%	Not covered
Acupuncture (medically necessary)[10]	$15 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$750 / $1,50 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$15 (ded. waived) / $40 / $70	Not covered
Tier 4 Specialty drugs[14]	30%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 PPO 2250/55

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$2,250 / $4,500	$4,500 / $9,000
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$55 (ded. waived)	50%
Specialist visit	$80 (ded. waived)	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$55 (ded. waived)	Not covered
X-ray/Laboratory procedures	$65 (ded. waived) / $40 (ded. waived)	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$80 (ded. waived)	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$55 (ded. waived)	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	$55 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$300 / $600 Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $85	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 Value PPO 1700/50

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,700 / $3,400	$3,400 / $6,800
Out-of-pocket maximum (single / family)[6]	$8,000 / $16,000	$16,000 / $32,000
Professional services Office visit[7]	$50 (ded. waived)	50%
Specialist visit	$75	50%
Telehealth services through Babylon[8]	$0 (ded. waived)	Not covered
Rehabilitation and habilitation therapy	$50 (ded. waived)	Not covered
X-ray/Laboratory procedures	$50 / $40	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	$75	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	$50 (ded. waived)	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	$50 (ded. waived)	Not covered
Chiropractic care	$25 (ded. waived) 12 visits max per year	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$1,700 / $3,400 Integrated med/Rx ded. Applies to tiers 2-4	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 (ded. waived) / $65 / $100	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

BKT033351EL00 (1/20)

EnhancedCare Silver 70 HDHP PPO 1400/40%

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Certificate of Insurance* (COI) should be consulted for a detailed description of coverage benefits and limitations.

Unless otherwise noted, the deductible applies.

Benefit description	Insured person(s) responsibility	
	IN-NETWORK[1,2]	**OUT-OF-NETWORK**[1,3]
Unlimited lifetime maximum.	✔	✔
Plan maximums Calendar year deductible[4]	$1,400 / $2,800	$2,800 / $5,600
Out-of-pocket maximum (single / family)[5,6]	$7,000 / $14,000	$14,000 / $28,000
Professional services Office visit[7]	40%	50%
Specialist visit	40%	50%
Telehealth services through Babylon[8]	$0	Not covered
Rehabilitation and habilitation therapy	40%	Not covered
X-ray/Laboratory procedures	40% / 40%	50% / 50%
Complex radiology services (MRI, CT, PET)	40%	50%
Outpatient services Outpatient surgery (ambulatory surgery center / hospital)	40% / 40%	50% / 50%
Hospital services Inpatient hospital	40%	50%
Skilled nursing facility	40%	50%
Emergency services Emergency room (copay waived if admitted)	40%	40%
Urgent care	40%	50%
Mental/Behavioral health / Substance use disorder services[9] Mental/Behavioral health / Substance use disorder (inpatient)	40%	50%
Mental/Behavioral health / Substance use disorder (outpatient office visit)	40%	50%
Other services Durable medical equipment	40%	Not covered
Acupuncture (medically necessary)[10]	40%	Not covered
Chiropractic care	$25 (unlimited visits)	Not covered
Prescription drug coverage[12,13] Prescription drug deductible (single / family)	$1,400 / $2,800 Integrated med/Rx ded. Applies to all tiers	Not covered
Prescription drugs Tier 1 / Tier 2 / Tier 3[11] (up to a 30-day supply obtained through a participating pharmacy)	$19 / $80 / $100	Not covered
Tier 4 Specialty drugs[14]	40%	Not covered
Pediatric dental[15] Diagnostic and preventive services	$0 (ded. waived)	10% (ded. waived)
Pediatric vision[16] Routine eye exam	$0 (ded. waived)	Not covered
Glasses (limitations apply)	$0 (ded. waived)	Not covered

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Plan Codes

Plan Name	Plan code without infertility	Plan code with infertility
Full Network HMO Platinum $0	GT0 (G-T-zero)	GT1 (G-T-one)
Full Network HMO Platinum $10	GT2	GT3
Full Network HMO Platinum $20	GT4	GT5
Full Network HMO Platinum $30	GT6	GT7
Full Network HMO Gold $30	GSO (G-S-Opera)	GSP
Full Network HMO Gold $35	GSQ	GSR
Full Network HMO Gold $40	GSS	GST
Full Network HMO Gold $50	GSU	GSV
Full Network HMO Silver $50	GTD	GTE
WholeCare HMO Platinum $0	GS7	GS8
WholeCare HMO Platinum $10	GS9	GSB
WholeCare HMO Platinum $20	GSC	GSD
WholeCare HMO Platinum $30	GSE	GSF
WholeCare HMO Gold $30	GRT	GRU
WholeCare HMO Gold $35	GRV	GRW
WholeCare HMO Gold $40	GRX	GRY
WholeCare HMO Gold $50	GRZ	GS0 (G-S-zero)
WholeCare HMO Silver $50	GSK	GSL
SmartCare HMO Platinum $0	GR1 (G-R-one)	GR2
SmartCare HMO Platinum $10	GR3	GR4
SmartCare HMO Platinum $20	GR5	GR6
SmartCare HMO Platinum $30	GR7	GR8
SmartCare HMO Gold $30	GQT	GQU
SmartCare HMO Gold $35	GQV	GQW
SmartCare HMO Gold $40	GQX	GQY
SmartCare HMO Gold $50	GQZ	GR0 (G-R-zero)
SmartCare HMO Silver $50	GR9	GRB
Salud HMO y Mas Platinum $0	GTP	GTQ
Salud HMO y Mas Platinum $10	GTR	GTS
Salud HMO y Mas Platinum $20	GTT	GTU
Salud HMO y Mas Platinum $30	GTV	GTW
Salud HMO y Mas Gold $30	GTF	GTG
Salud HMO y Mas Gold $35	GTH	GTI (G-T-India)
Salud HMO y Mas Gold $40	GTJ	GTK
Salud HMO y Mas Gold $50	GTL	GTM
Salud HMO y Mas Silver $50	GU1 (G-U-one)	GU2
CommunityCare HMO Silver $1750/$50	GRG	GRH
CommunityCare Bronze 60 HMO 6300/65 + Child Dental	GRC	GRD

(continued)

Plan Name	Plan code without infertility	Plan code with infertility
Platinum 90 PPO 0/15 + Child Dental	GP7	GP8
Platinum 90 PPO 250/15 + Child Dental Alt	GP9	GPB
Gold 80 PPO 0/30 + Child Dental Alt	GOV (G-Opera-V)	GOW (G-Opera-W)
Gold 80 PPO 350/25 + Child Dental	GOX (G-Opera-X)	GOY (G-Opera-Y)
Gold 80 PPO 500/20 + Child Dental Alt	GOZ (G-Opera-Z)	GP0 (G-P-zero)
Gold 80 PPO 1000/30 + Child Dental Alt	GP1 (G-P-one)	GP2
Gold 80 PPO 1500/0 + Child Dental Alt	GP3	GP4
Gold 80 Value PPO 750/15 + Child Dental Alt	GP5	GP6
Silver 70 PPO 2250/50 + Child Dental	GPC	GPD
Silver 70 PPO 2250/55 + Child Dental Alt	GPE	GPF
Silver 70 Value PPO 1700/50 + Child Dental Alt	GPI (G-P-India)	GPJ
Silver 70 HDHP PPO 1400/40% + Child Dental Alt	GPG	GPH
Bronze 60 PPO 6300/65 + Child Dental	GOR (G-Opera-R)	GOS (G-Opera-S)
Bronze 60 HDHP PPO 7000/0% + Child Dental	GOT (G-Opera-T)	GOU (G-Opera-U)
EnhancedCare Platinum 90 PPO 250/15 + Child Dental Alt	GPU	GPV
EnhancedCare Gold 80 PPO 0/30 + Child Dental Alt	GPK	GPL
EnhancedCare Gold 80 PPO 500/20 + Child Dental Alt	GPM	GPN
EnhancedCare Gold 80 PPO 1000/30 + Child Dental Alt	GPO (G-P-Opera)	GPP
EnhancedCare Gold 80 PPO 1500/0 + Child Dental Alt	GPQ	GPR
EnhancedCare Gold 80 Value PPO 750/15 + Child Dental Alt	GPS	GPT
EnhancedCare Silver 70 PPO 2250/55 + Child Dental Alt	GPW	GPX
EnhancedCare Silver 70 Value PPO 1700/50 + Child Dental Alt	GQ0 (G-Q-zero)	GQ1 (G-Q-one)
EnhancedCare Silver 70 HDHP PPO 1400/40% + Child Dental Alt	GPY	GPZ
PureCare Platinum 90 HSP 0/15 + Child Dental	GRO (G-R-Opera)	GRQ
PureCare Gold 80 HSP 350/25 + Child Dental	GRM	GRN
PureCare Silver 70 HSP 2250/50 + Child Dental	GRR	GRS
PureCare Bronze 60 HSP 6300/65 + Child Dental	GRK	GRL

Infertility buy-up details

For HMO/HSP plans only

- There is an $8,500 lifetime maximum on infertility services and a separate $1,500 lifetime limit on prescription medications for infertility.
- Infertility benefits do not apply to the calendar year out-of-pocket maximum.

For PPO/EnhancedCare PPO insurance plans only

- There is a $2,000 lifetime maximum on infertility services and a separate $2,000 lifetime limit on prescription medications for infertility.
- Infertility benefits do not apply to the calendar year out-of-pocket maximum (with the exception of HDHP plans).

Footnotes

Platinum $0, Platinum $10, Platinum $20, Platinum $30, Gold $30, Gold $35, Gold $40, Gold $50, Silver $50, and SIMNSA

[1]Preventive care services are covered for children and adults, as directed by your physician, based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations; immunizations; and diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Babylon to provide telehealth services. Babylon services are not intended to replace services from your physician, but are a supplemental service. Provider participation requirements may apply to specialist referrals. See your health coverage document for information regarding which providers are available with your health coverage. Access to telehealth services does not guarantee that a prescription will be written.

[3]MinuteClinics are not located in all California counties. Refer to www.minuteclinic.com for the most up-to-date locations.

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

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Self-injectable drugs (other than insulin) are considered specialty drugs. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

[12]In Mexico, all providers, facilities and pharmacies must belong to the SIMNSA Network, except for emergency services.

[13]Any copayment or coinsurance paid for covered services in either the Salud Network or the SIMNSA Network will be credited to the individual OOPM of both networks.

[14]Mental health and substance abuse services must be provided by a SIMNSA provider.

CommunityCare HMO

[1]Preventive care services are covered for children and adults, as directed by your physician, based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations; immunizations; and diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Babylon to provide telehealth services. Babylon services are not intended to replace services from your physician, but are a supplemental service. Provider participation requirements may apply to specialist referrals. See your health coverage document for information regarding which providers are available with your health coverage. Access to telehealth services does not guarantee that a prescription will be written.

[3]MinuteClinics are not located in all California counties. Refer to www.minuteclinic.com for the most up-to-date locations.

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

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Self-injectable drugs (other than insulin) are considered specialty drugs. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

[12](Bronze only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits, outpatient mental health/ substance abuse): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

PureCare HSP

[1]Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S.Preventive Services Task Force Grade A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[2]Health Net contracts with Babylon to provide telehealth services. Babylon services are not intended to replace services from your physician, but are a supplemental service. Provider participation requirements may apply to specialist referrals. See your health coverage document for information regarding which providers are available with your health coverage. Access to telehealth services does not guarantee that a prescription will be written.

[3](Bronze only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits, outpatient mental health/ substance abuse): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

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

[5]Acupuncture care is administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

[6]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. The brand-name prescription drug deductible, or medical deductible if applicable, must be paid before Health Net begins to pay for brand-name prescription drugs, including brand-name specialty drugs.

[7]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[8](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[9]Tier 4 drugs include when: Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[10]Pediatric dental plans are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's *Evidence of Coverage* (EOC) for details.

[11]Pediatric vision benefits are provided by Health Net of California, Inc. Health Net of California, Inc. contracts with Envolve Vision Inc., to administer vision benefits.

PPO

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* (COI) for terms and conditions of coverage.

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the COI 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 COI for out-of-network reimbursement methodology.

[4]Any amount applied toward the calendar year deductible (if applicable) 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. Unless otherwise specified, deductible applies to all services.

[5](Silver HDHP only) For single coverage, the deductible is $1,400. For family coverage, the deductible is $2,800, and there is no per member deductible accumulation/accrual. It is a single comprehensive family deductible.

[6]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and copayments or coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.

[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]Health Net contracts with Babylon to provide telehealth services. Babylon services are not intended to replace services from your physician, but are a supplemental service. Provider participation requirements may apply to specialist referrals. See your health coverage document for information regarding which providers are available with your health coverage. Access to telehealth services does not guarantee that a prescription will be written.

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

[10](Bronze non-HDHP plan only) Visits 1–3 (combined between office visits, urgent care, prenatal and postnatal visits): The calendar year deductible is waived. Visits 4–unlimited: The calendar year deductible applies.

[11]Acupuncture care is underwritten by Health Net Life Insurance Company for PPO plans.

[12]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. 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 COI for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your COI and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The COI is a legal, binding document. If the information in this brochure differs from the information in the COI, the COI controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[13]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[14](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[15]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[16]Pediatric dental PPO plans are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services (DBP). DBP is not affiliated with Health Net. See the plan's COI for details.

[17]Pediatric vision benefits are provided by Health Net Life Insurance Company. Health Net Life Insurance Company contracts with Envolve Vision Inc., to administer vision benefits.

EnhancedCare PPO

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* (COI) for terms and conditions of coverage.

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the COI 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 COI for out-of-network reimbursement methodology.

[4]Any amount applied toward the calendar year deductible (if applicable) 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. Unless otherwise specified, deductible applies to all services.

[5](Silver HDHP only) For single coverage, the deductible is $1,400. For family coverage, the deductible is $2,800, and there is no per member deductible accumulation/accrual. It is a single comprehensive family deductible.

[6]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and copayments or coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers.

[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]Health Net contracts with Babylon to provide telehealth services. Babylon services are not intended to replace services from your physician, but are a supplemental service. Provider participation requirements may apply to specialist referrals. See your health coverage document for information regarding which providers are available with your health coverage. Access to telehealth services does not guarantee that a prescription will be written.

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

[10]Acupuncture care is underwritten by Health Net Life Insurance Company for EnhancedCare PPO plans.

[11]The three prescription drug tiers are: Tier 1 – Most generic drugs and low-cost preferred brands. Tier 2 – Non-preferred generic drugs; preferred brand-name drugs; or drugs recommended by the plan's Pharmacy & Therapeutics (P&T) Committee based on drug safety, efficacy and cost. Tier 3 – Non-preferred brand-name drugs; drugs recommended by the P&T Committee based on drug safety, efficacy and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier. 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 COI for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your COI and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The COI is a legal, binding document. If the information in this brochure differs from the information in the COI, the COI controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[12]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration (FDA) are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[13](Platinum, Gold, and Silver only) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $250 for an individual prescription of up to a 30-day supply or $750 for a 90 day supply prescription through mail order, after any applicable deductible has been met. (Bronze) Tiers 1-4 drugs will have a copayment and coinsurance maximum of $500 for an individual prescription of up to a 30-day supply or $1,500 for a 90 day supply prescription through mail order, after any applicable deductible has been met.

[14]Tier 4 drugs include when: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies; or self-administration requires training, clinical monitoring; or the drug was manufactured using biotechnology; or the plan's cost (net of rebates) is greater than $600. Specialty drugs include high-cost medications used to treat complex medical conditions, including covered self-injectable drugs other than insulin. Specialty drugs require prior authorization and must be obtained from a contracted specialty pharmacy vendor.

[15]Pediatric dental PPO plans are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Administrative Services (DBP). DBP is not affiliated with Health Net. See the plan's COI for details.

[16]Pediatric vision benefits are provided by Health Net Life Insurance Company. Health Net Life Insurance Company contracts with Envolve Vision Inc., to administer vision benefits.

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HEALTH NET
PO Box 9103
Van Nuys, CA 91409-9103

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