

Refer to your Certificate of Insurance for complete details, exclusions and limitations. In case of conflict, the Certificate of Insurance controls. Benefits subject to deductible unless noted.

LIFETIME MAXIMUM: \$6 million

ANNUAL DEDUCTIBLES

(Not included in annual out-of-pocket maximum.)

ANNUAL OUT-OF-POCKET MAXIMUM

(Does not include annual deductible. Payments for services not covered by this plan will not apply to this yearly out-of-pocket maximum.)

PROFESSIONAL SERVICES

Visit to physician (including specialist consultations)

X-ray and laboratory procedures¹

ADULT PREVENTIVE CARE (age 19 and older)

Annual routine physical exam, annual OB/GYN exams (breast exam and pelvic exam, Pap smears and mammography²), annual prostate cancer screening and exam.

CHILD PREVENTIVE CARE (newborns to age 18)

Checkups, immunizations, vision and hearing exams

EMERGENCY HEALTH COVERAGE

Emergency room (professional and facility charges)

Urgent care center (facility charges)

Ambulance

OUTPATIENT SERVICES¹

Outpatient Surgery (hospital or outpatient surgery center charges only) (out-of-network maximum allowable charge is \$600 per day)

Outpatient facility services¹

HOSPITALIZATION SERVICES¹

Inpatient, semi-private hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and substance abuse treatment) (out-of-network maximum allowable charge is \$600 per day)

Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)

MATERNITY CARE

OTHER SERVICES

Rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy)

Chiropractic care / Acupuncture

Mental health for non-severe conditions³

Diabetic equipment

Durable medical equipment (\$2,000 maximum payable per calendar year)

Radiation and chemotherapy

Prescribed home infusion therapy & home health care

Skilled nursing confinement and inpatient rehabilitation (up to 100 visits)

Hospice care

Adult Immunizations

Transplant⁴

OUTPATIENT PRESCRIPTION DRUGS^{5,6}

(medical deductible waived) (up to a 30-day supply) (does not count towards your annual out-of-pocket maximum) [Prescription drugs filled through participating mail order (up to a 90-day supply) require twice the level of copay.]

	IN-NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY
	\$6,000	
	\$0	\$6,000
	\$40 copay (Deductible waived for first 2 visits of any combination of Professional Services and Preventive Care)	50%
	No charge after deductible is met	50%
	\$40 copay (Deductible waived for first 2 visits of any combination of Professional Services and Preventive Care)	Not covered
	\$40 copay (Deductible waived for first 2 visits of any combination of Professional Services and Preventive Care)	Not covered
	No charge after deductible is met	
	No charge after deductible is met	
	No charge after deductible is met	
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	Not covered	
	Inpatient: No charge after deductible is met; Outpatient: Not covered	Inpatient: 50% Outpatient: Not covered
	Not covered	
	Inpatient ¹ : No charge after deductible is met; Outpatient: Not covered	Inpatient ¹ : 50% Outpatient: Not covered
	No charge after deductible is met	Not covered
	No charge after deductible is met	Not covered
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	No charge after deductible is met	50%
	No charge after deductible is met	Not covered
	No charge after deductible is met	Not covered
	Generic only - \$10 Level I	Not covered

¹Certain services require prior certification from Health Net. Without prior certification, benefit is reduced by 50%. Refer to the Certificate of Insurance for details. ²Mammograms are covered at the following intervals: one exam between the ages 35-39, one every 24 months for ages 40-49 and one every year for age 50 and older. ³Inpatient is 20 visits with \$300 maximum allowable per day. ⁴Only transplant services and supplies provided to participants at a facility approved by HNL will be considered under this benefit. ⁵Refer to the Certificate of Insurance for complete information on prescription drugs. ⁶Prescription drug charges do not apply to your maximum out-of-pocket limit. Health Net Life Insurance Company is a subsidiary of Health Net, Inc. Health Net® is a registered service mark of Health Net, Inc. All rights reserved. California Farm Bureau Members' health insurance plans are underwritten by Health Net Life Insurance Company. Farm Bureau logo is a registered service mark of American Farm Bureau Federation used under license by Health Net.

Health Net Life Insurance Company California Farm Bureau Member Health Insurance Plans

Major Medical Expense Coverage Outline of Coverage

READ YOUR CERTIFICATE CAREFULLY

This outline of coverage provides a brief description of the important features of your Certificate of Insurance (Certificate). This is not the insurance contract and only the actual Certificate provisions will control. The Certificate itself sets forth, in detail the rights and obligations of both you and Health Net Life Insurance Company. It is, therefore, important that you read your Certificate carefully!

MAJOR MEDICAL EXPENSE COVERAGE

This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out of hospital care and prosthetic appliances subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the Certificate. Basic hospital or basic medical insurance coverage is not provided.

PRINCIPAL BENEFITS AND COVERAGES

Please refer to the summary of each plan's covered services and supplies. Also refer to the Certificate you receive after you enroll in a plan. The Certificate offers more detailed information on the benefits and coverage included in your health insurance plan.

EXCLUSIONS AND LIMITATIONS

The following is a partial list of services that are not generally covered. For complete details on any plan's exclusions and limitations, please see the Health Net Life California Farm Bureau Members' Health Plan Certificate.

- Services or supplies that are not medically necessary
- Any amounts in excess of the maximum amounts specified in the Certificate
- Pregnancy or maternity services except as specified in the Certificate
- Cosmetic surgery except as specified in the Certificate
- Contraceptive drugs and/or certain contraceptive devices are covered as specified in the Certificate. Vaginal contraceptives devices are only covered when a Physician prescribes the device and performs a fitting examination as specified in the Certificate
- Dental services except as specified in the Certificate
- Treatment and services for Temporomandibular (Jaw) Joint Disorders
- Surgery and related services for the purposes of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are Medically Necessary
- Food or dietary, nutritional supplements, except for formulas and special food products to prevent complications of Phenylketonuria (PKU)
- Vision care including certain eye surgeries to replace glasses, except as specified in the Certificate
- Optometric services or eye exercises, except as specifically stated elsewhere in the Certificate
- Eye glasses or contact lenses and eyeglasses, except as specified in the Certificate
- Sex changes
- Services to reverse voluntary surgically induced infertility
- Services or supplies that are intended to impregnate a woman are not covered
- Certain genetic testing
- Experimental or investigative services
- Routine physical exams, except for preventive care services (e.g., physical exam for insurance, licensing, employment, school, or camp.) Any physical, vision or hearing exams which are not related to diagnosis or treatment of illness or injury, except as specifically stated in Certificate
- Immunizations or inoculations for adults or children, except as described in the "Medical Benefits" section or for foreign travel or occupational purposes
- Services not related to a covered illness or injury
- Custodial or domiciliary care
- Inpatient room and board charges incurred in connection for an admission to a Hospital or other Inpatient treatment facility primarily for diagnostic tests which could have been performed safely on an outpatient basis
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain
- Any services or supplies furnished by a non-eligible institution, which is other than a legally operated Hospital or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated
- Expenses in excess of a Hospital's (or other Inpatient facility's) most common semi-private room rate
- Infertility services
- Allergy serum
- Private duty nursing
- Mental and nervous disorder and substance abuse treatment, except as specified in the Certificate
- Hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation However, certain of the above conditions shall be covered as outlined in the Certificate

- Over-the-counter medical supplies and medications
 - Personal comfort items
 - Orthotics, unless custom made to fit the Covered Person's body and as specified in the Certificate
 - However, the Certificate does cover Medically Necessary diabetic equipment as shown in the "Medical Supplies" portion of "Schedule of Benefits" and the "Diabetic Equipment" provision in the "Medical Benefits" section
 - Educational services or nutritional counseling, except as specified in the Certificate
 - Hearing aids
 - Obesity related services
 - Any services received by Medicare benefits without payment of additional premium
 - Services received before your effective date of coverage
 - Services received after coverage ends
 - Services for which no charge is made to the Covered Person in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency
 - Physician self-treatment
 - Services provided by immediate family members
 - Conditions caused by the Covered Person's commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition
 - Conditions caused by release of nuclear energy, when government funds are available
 - Any services provided by or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare
 - Services for conditions of pregnancy for a surrogate parent are covered, but when compensation is obtained for the surrogacy, we shall have a lien on such compensation to recover its medical expense
 - Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as stated in the Certificate
 - Sexual dysfunction drugs
 - Rehabilitative services rendered in an outpatient facility, are not covered except as specified in the Certificate
 - Rehabilitation therapy services are not covered when provided in connection with the treatment of the following conditions:
 - Psychosocial speech delay (includes delayed language development)
 - Mental retardation or dyslexia
 - Attention deficit disorders and associated behavior problems
 - Developmental articulation and language disorders
- However, some of the above conditions shall be covered as shown in the "Schedule of Benefits" section, if Medically Necessary as described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness," and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence
- Outpatient speech therapy, except as specified in the Certificate
 - Services and supplies obtained while in a foreign country with the exception of Emergency Care
 - Home birth

Some services require pre-certification from Health Net prior to receiving services. Please refer to your Certificate for details on what services and procedures require pre-certification.

Health Net Life does not require pre-certification for dialysis services or maternity care. However, please call the Customer Contact Center at 800-839-2172 upon initiation of dialysis services or at the time of the first prenatal visit.

PRE-EXISTING CONDITIONS

Covered services will not include any care required in connection with the treatment of any condition, disease or injury for which medical advice, diagnosis, care or treatment, including the use of prescription medications, was recommended by or received from a licensed health care practitioner during the six months immediately preceding the effective date of coverage under the Certificate. Credit will be given toward the pre-existing condition waiting period for membership with another creditable health care plan if you apply for coverage under Health Net Life's California Farm Bureau Members' Health Insurance Program plans within 62 days of termination with the previous plan.

Reproductive Health Services

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Certificate of Insurance and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Life's Customer Contact Center at 800-839-2172 to ensure that you can obtain the health care services that you need.