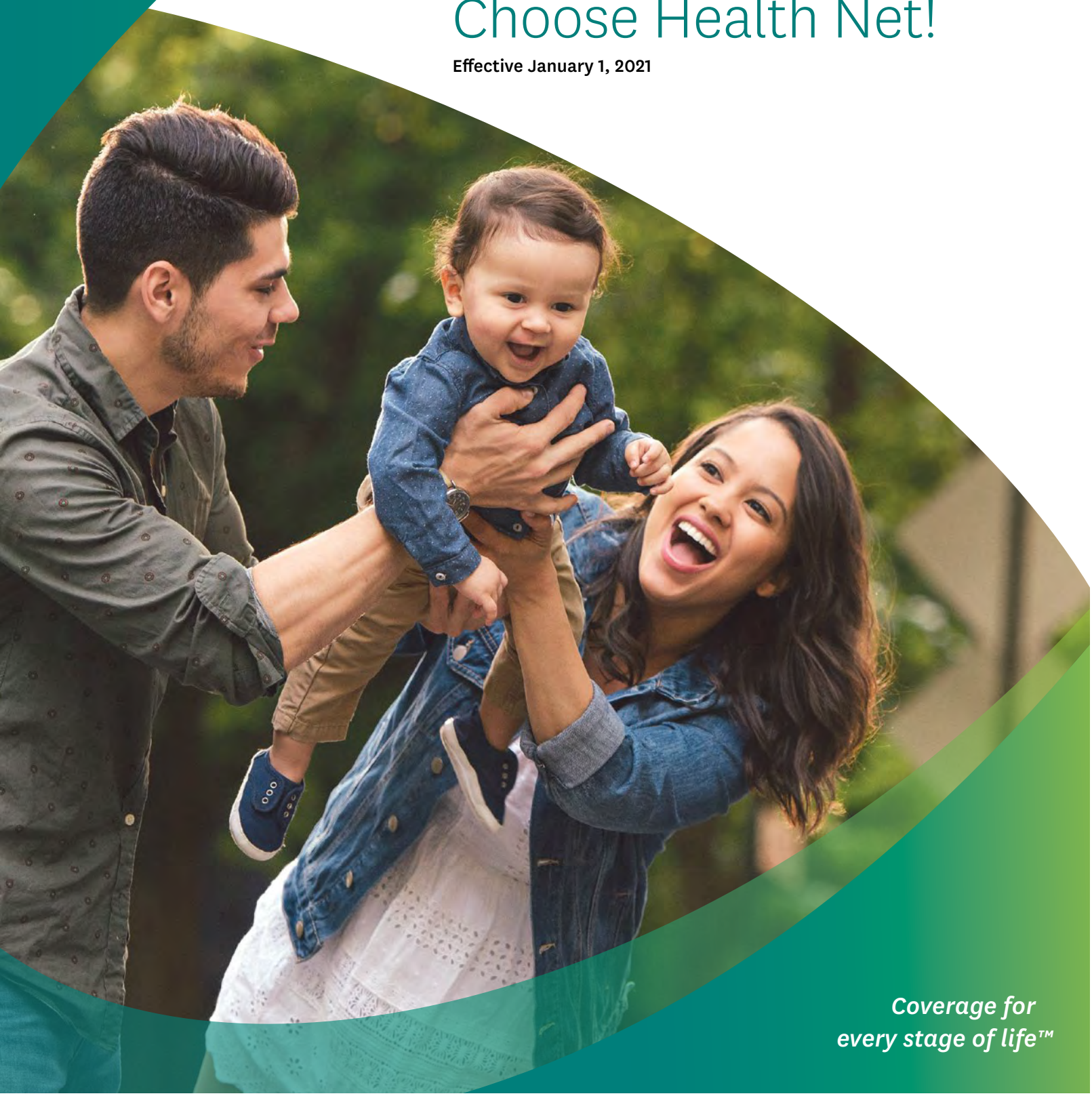
Health Net®

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

INDIVIDUAL & FAMILY PLANS
AVAILABLE DIRECTLY THROUGH HEALTH NET

Take Action and Choose Your Health Coverage. Choose Health Net!

Effective January 1, 2021



Coverage for every stage of life™

Whether you're new to Health Net, or coming back to us for 2021, there are several things to know about our plans and our people:

- *We offer affordable, quality health coverage for individuals and families.*
- *Through our local doctor networks, we help people get the care they need through every stage of their life and health.*
- *Like you, we live and work in California.*
- *You can enroll in these plans directly through Health Net.*

Take a look inside to see what Health Net has ready and waiting for you.

What you'll find inside...

The Value of Health Coverage

You may wonder if there have been any changes in the law that may impact you and your family. You may also wonder why you need health care coverage. Here are some things you should know.

How the rules impact you in California

For 2021 the following information applies:

- California requires individuals to have health insurance or pay a state tax penalty.
- All individual and family plans must offer coverage for 10 essential health benefits. These include maternity care, mental health, hospitalization, pediatric dental and more.

Coverage gives you peace of mind

Did you know a three-day hospital stay can cost as much as $30,000?[1] Costs like these are what make buying health coverage worth your hard-earned money. Health coverage helps you:

- Pay for major medical costs if you get sick or hurt. Costs related to an accident or illness can quickly add up. And cost is the last thing you want to worry about if an emergency comes up.
- Stay healthy with checkups, vaccines and health screenings. It also helps cover the cost of prescription drugs and expenses related to managing chronic illness.

Choose the peace of mind that comes with having health coverage!
Make Health Net your plan for 2021.

[1]https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/

2021 Enrollment Period

You can sign up for new health coverage or change your existing health coverage for 2021.

Enrollment begins: November 1, 2020.

Enrollment ends: January 31, 2021.

Some key dates to keep in mind:

- For health coverage to start immediately on January 1, enroll by December 15. You must make your first premium payment before your coverage can start.
- Last day to enroll for coverage in 2021 is January 31. Enroll by January 31 for your health coverage to start February 1. After that, you can enroll only if you qualify for a special event.

Some examples of events that qualify you to enroll after January 31 are:

- Losing a job that provided coverage.
- Having or adopting a baby.
- Having a major income change.
- Getting married or divorced.
- Moving outside a service area.

Your enrollment checklist

- ☑ Do the doctors, specialists and providers in the plan network fit your health needs?
- ☑ Are the plan's deductible, copay and coinsurance amounts right for your budget?

Ways to Enroll

When you're ready to sign up for Health Net coverage, we're here to help make it easy!

- Call our Health Net sales team at **1-877-609-8711**.
- Go to **www.myhealthnetca.com**.
- **Visit** your local broker.

Rules for 2021

For 2021, Californians must have health care coverage or pay a penalty. You'll pay the penalty when you file your state taxes. To avoid paying the state penalty, individuals may qualify for an exemption.

In 2020, the penalty for not having coverage for the entire year was the higher of these two amounts:

- **2.5% of your yearly gross household income.**
- **$750 per adult / $375 per child under 18.**

You can learn about exemptions and confirm the penalty for the 2021 tax year at www.coveredca.com/individuals-and-families/getting-covered/penalty-and-exemptions/.

Find Your Costs and Coverage Levels

There are two kinds of costs that come with having health coverage:

Monthly premium

This is what you pay to keep your health coverage current. You pay it directly to Health Net. You pay it monthly, whether or not you use services.

Copayment or coinsurance

This is the amount you pay when you use health services, called out-of-pocket costs. You pay it directly to the doctor, pharmacy or other provider (e.g., lab, hospital).

Some health plans have a deductible. This is the amount you owe for some covered health care services before your health plan begins to pay for those services. After you pay your deductible, covered services are still subject to other cost sharing like copayments and coinsurance.

Find the right level of coverage

Choosing the right plan depends on your health care needs. It also depends on your budget and lifestyle. There is a trade-off between the price of your monthly premium and the amount you pay when you need medical care.

Higher monthly premium

+

Lower out-of-pocket costs

or

Higher out-of-pocket costs

+

Lower monthly premium

Here are two examples:

Sam is in his early 50s and sees the doctor often for high blood pressure. He has had a couple of surgeries and may need another. **Sam chooses a plan with a higher monthly premium payment. His plan also covers more of the out-of-pocket costs of the services he uses, which means he will likely pay less for each doctor visit or treatment.**

Lee is 27 and rarely ill. She wants a health plan that keeps her covered but costs her less. **Lee picks a plan with a lower monthly premium payment. She knows it will cost more to see a doctor, but she plans to put money aside in case she has an unexpected health expense.**

Important tip: Check out the Health Care Definitions on page 19 if you are confused about a health care word.

The Benefits of Health Net

Health Net gives you a choice of health plans – and a whole lot more.

Take care with Health Net

When you choose Health Net, you can count on:

- Doctor visits when you need care
- Flu shots. Mammograms. Vaccines for kids
- Medical advice any time of day or night and on weekends
- Urgent care and hospital services when you need them

Fill your prescriptions

Health Net's Essential Rx Drug List is a list of prescription drugs covered by your plan. The Essential RX Drug List can be found at www.myhealthnetca.com under the Pharmacy Information section.

- Use pharmacies in your health plan's pharmacy network
- Select generic drugs to reduce your out-of-pocket costs
- Take advantage of our mail order program for your prescriptions for chronic conditions

Talk to a nurse anytime

Health Net is here for your health with licensed nurses available 24/7 by phone. Our nurses can help you figure out what to do next about:

- Caring for minor injuries and illnesses like fevers and the flu
- Urgent health situations
- Preparing for doctor visits
- Other health questions

Get an online account

Having an online account can help you understand and manage your Health Net plan. Use our member portal to:

- Print ID cards
- See your plan details
- View pharmacy benefits or find a pharmacist near you
- Change your primary doctor/PCP
- Find programs for weight management, stopping smoking and more
- Know when to get health screenings

No cost Babylon telehealth services

Babylon is an option when you can't see your regular doctor. When you choose any Health Net Individual & Family Plans coverage, you can use the Babylon app to:

- **Book a video appointment with a health care provider.**
- **Get non-emergency care for mental health, allergies, cough, congestion, fever, pain and more from anywhere.**
- **The Babylon chatbot can analyze your symptoms and provide information on potential causes and possible next steps. If medical care is needed, you can access a health care provider via video call or get help finding additional medical services.**

Learn Where to Get Care

Our plans offer a variety of ways to get the care you need, when you need it.

At a doctor's office

At home

In a clinic

Your primary doctor

Go to your primary doctor (also called your primary care physician or PCP) for routine and preventive care. This includes annual wellness exams, illness, vaccinations, and general medical care.

Other in-network providers

Get care from other doctors, specialists or providers (like urgent care or hospitals) in your network.[1] *PCP referral required on our CommunityCare HMO plans.*[2]

For CommunityCare HMO, PureCare HSP and PureCare One EPO, there is no coverage for out-of-network services except for emergency care, urgent care and services approved by Health Net.

To find providers in your plan's network, visit myhealthnetca.com and click on *Find a Doctor*.

MHN Network Providers

Get mental health services like:

- Counseling
- Psychotherapy
- Treatment for addiction
- Psychiatric services

You don't need a referral from your primary doctor. And, you can check to see if you can obtain your sessions by phone or videochat.

Telehealth

See if your doctor offers telehealth services. Telehealth services through your doctor are subject to the same copayments as if the service was delivered in person.

You can also use the Babylon app for phone or online video consults with a telehealth doctor or therapist. Ideal when you can't meet with your primary doctor or their office is closed.[1]

24/7 Nurse advice line

Get advice from a registered nurse on whether to seek medical care or how to care for illness and injury at home, like self-care for minor injuries and illness like fevers and the flu.[1]

Heal

Schedule a visit with a board-certified doctor, at your home, office or hotel. They do primary, preventive and urgent care "house calls." Available from 8:00 a.m.–8:00 p.m., seven days a week. (By appointment in some cities.)[1]

Heal is available by appointment in select urban areas, including Berkeley, Oakland, Long Beach, Los Angeles, Orange County, San Diego, San Francisco, Bay Area, and Sacramento. Heal is not available on CommunityCare HMO and PureCare HSP plans.

Walk-in retail clinics

Go to a walk-in retail clinic, such as MinuteClinics (found in select CVS Pharmacy stores), when you need care for common illnesses.[1]

Urgent care centers

Get same-day care for non-emergency illnesses or injuries.[1] Some urgent care centers now offer X-rays and lab tests, too.

[1]Go straight to the nearest emergency room or call 911 if you have an emergency.

[2]Self-referrals are allowed for obstetrician and gynecological services and reproductive and sexual health care services.

Explore Your Health Net Plan Choices

For more than 40 years, Californians have looked to us for health coverage that fits their health and budget. Now's the time for you to choose Health Net!

We're ready to be part of your health coverage team in 2020. Call us – we are here to help you choose. Just call 1-877-609-8711.

Let us help you find the plan that's right for you.

Choose by Location

You want and deserve health coverage you can count on. That's where Health Net comes in. You can choose from a variety of Health Net plans through Covered California.

The plans available to you are based on your county:

County	Region	CommunityCare HMO	PureCare HSP	PureCare One EPO	EnhancedCare PPO	PPO
Contra Costa	5			✔		✔
Kern County[3]	14	✔	✔	✔		✔
Los Angeles: ZIP codes starting with 906-912, 915, 917, 918, 935	15	✔	✔	✔	✔	✔
Los Angeles: ZIP codes not in Region 15	16	✔	✔		✔	
Marin	2			✔		✔
Merced	10			✔		✔
Napa	2			✔		✔
Orange	18	✔	✔	✔	✔	✔
Placer[3]	3				✔	
Riverside[3]	17	✔	✔	✔	✔	✔
Sacramento	3				✔	
San Bernardino[3]	17	✔	✔	✔	✔	✔
San Diego	19	✔	✔	✔	✔	✔
San Francisco	4			✔		✔
San Joaquin	10			✔		✔
San Mateo	8			✔		✔
Santa Clara	7			✔		✔
Santa Cruz	9			✔		✔
Solano	2			✔		✔
Sonoma	2			✔		✔
Stanislaus	10			✔		✔
Tulare	10			✔		✔
Yolo	3				✔	

[3]Partial county – not all ZIP codes available.

You can enroll in any of the plans we offer in your location.

CommunityCare HMO Plans

AVAILABLE DIRECTLY THROUGH HEALTH NET

Important tip: Use the CommunityCare HMO Network for all covered services. If you need a specialist, your PCP will refer you to one.[1] There is no coverage for out-of-network services except for emergency care, urgent care and services approved by Health Net.

Our HMO plans might be right for you if you prefer:

- *More predictable costs, and*
- *One familiar doctor to oversee your care*

Your primary care physician (PCP or primary doctor) will refer you to specialists and facilities in the CommunityCare HMO network, when you need it.[1]

For prescription medicine, you can go to any pharmacy in the Advanced Choice Pharmacy Network. It includes CVS Pharmacy, Safeway, Costco, Vons, and others.

[1]Self-referrals are allowed for obstetrician and gynecological services and reproductive and sexual health care services.

CommunityCare HMO plans – Your share of costs

The amounts shown here are what you would pay for the services you use with each plan. With Gold 80 CommunityCare HMO, for example, your cost for a doctor office visit is $35.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Platinum 90 CommunityCare HMO	Gold 80 CommunityCare HMO	Silver 70 Off Exchange CommunityCare HMO
Deductible For one person / For family	$0 / $0	$0 / $0	$4,000 / $8,000
Out-of-pocket maximum For one person / For family	$4,500 / $9,000	$8,200 / $16,400	$8,200 / $16,400
Doctor office visit	$15	$35	$40[1]
Telehealth consultations through the select telehealth services provider[2]	$0	$0	$0[1]
Specialist	$30	$65	$80[1]
Hospital stay	Facility: $250[3]; Physician: $0	Facility: $600[3]; Physician: $0	Facility: 20%; Physician: 20%[1]
Outpatient surgery	Facility: $100; Physician: $25	Facility: $300; Physician: $40	20%[1]
Urgent care	$15	$35	$40[1]
Emergency care[4]	Facility: $150; Physician: $0	Facility: $350; Physician: $0	Facility: $400[1]; Physician: $0[1]
Prescription drugs Tier 1 (most generics and low-cost preferred brands) Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only)	$5 / $15 / $25	$15 / $55 / $80	$16 / $60 / $90 Prescription drug calendar year deductible is $300 per member / $600 per family

This is a summary only. The CommunityCare HMO disclosure has plan overviews with more details about what services are covered with our CommunityCare HMO plans. The deductible applies unless otherwise noted. Pediatric dental and vision services are covered until the last day of the month in which the child turns age 19.

[1]Your medical deductible does not apply to these services.

[2]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[3]Per day, up to five days.

[4]You do not pay the copayment if you are admitted to the hospital.

PureCare HSP Plans

AVAILABLE DIRECTLY THROUGH HEALTH NET

Important tip: Use the Health Net PureCare HSP provider network for all covered services. There is no coverage for out-of-network services except for emergency care, urgent care and services approved by Health Net.

Our Health Care Services Plans (HSPs) are similar to HMOs. You choose a primary care physician (PCP or primary doctor) who can help guide your care. There's one big difference. With an HSP, your PCP does not need to refer you to a specialist. You can see any specialist as long as they are in the PureCare HSP network.

You can choose from these two plans levels, a Bronze 60 or Minimum Coverage plan.

PureCare HSP plans – Your share of costs

The amounts shown here are what you would pay for the services you use with each plan. With Bronze 60 PureCare HSP, for example, your cost for a doctor office visit is $65.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Bronze 60 PureCare HSP	Minimum Coverage PureCare HSP[1]
Deductible For one person / For family	$6,300 / $12,600	$8,550 / $17,100
Out-of-pocket maximum For one person / For family	$8,200 / $16,400	$8,550 / $17,100
Doctor office visit	$65[2]	0%[2]
Telehealth consultations through the select telehealth services provider[3]	$0	0%[2]
Specialist	$95[2]	0%
Hospital stay	40%	0%
Outpatient surgery	40%	0%
Urgent care	$65[2]	0%[2]
Emergency care[4]	Facility: 40%; Physician: $0[5]	Facility: 0%; Physician: $0[5]
Prescription drugs Prescription drug calendar year deductible	$500 per member / $1,000 per family	
Tier 1 (most generics and low-cost preferred brands)	$18/script (after Rx deductible)	0%[6]
Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only)	40% up to $500/script (after Rx deductible)	0%[6]

This is a summary only. The PureCare HSP disclosure has plan overviews with more details about what services are covered with our PureCare HSP plans. The deductible applies for medical services and prescription drugs. Pediatric dental and vision services are covered until the last day of the month in which the child turns age 19.

[1]Minimum coverage plans are available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this plan.

[2]The first three visits are not subject to the deductible. You just pay the copayment. For visits 4 and more, you pay the full cost until you have paid your deductible.

[3]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[4]You do not pay the copayment if you are admitted to the hospital.

[5]Your deductible does not apply to these services.

[6]Your medical deductible applies to prescription drugs for all tiers.

PureCare One EPO Insurance Plans

AVAILABLE DIRECTLY THROUGH HEALTH NET

Important tip: Use the Health Net PureCare One EPO provider network for all covered services. There is no coverage for out-of-network services except for emergency care, urgent care and services approved by Health Net.

If you live in Central and Northern California, you can choose an Exclusive Provider Organization (EPO) plan.

You select a primary care physician (PCP or primary doctor) from the PureCare One EPO network. Your PCP helps guide your care. With an EPO plan, you can choose to get care from specialists in the network and you don't need a referral from your PCP.

You can choose from the full range of metal level plans (Platinum, Gold, Silver, Bronze, and Minimum Coverage).

PureCare One EPO insurance plans – Your share of costs

The amounts shown here are what you would pay for the services you use with each plan. With Gold 80 PureCare One EPO, for example, your cost for a doctor office visit is $35.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Platinum 90 PureCare One EPO	Gold 80 PureCare One EPO	Silver 70 Off Exchange PureCare One EPO	Bronze 60 PureCare One EPO	Minimum Coverage PureCare One EPO[1]
Deductible For one person / For family	$0 / $0	$0 / $0	$4,000 / $8,000	$6,300 / $12,600	$8,550 / $17,100
Out-of-pocket maximum For one person / For family	$4,500 / $9,000	$8,200 / $16,400	$8,200 / $16,400	$8,200 / $16,400	$8,550 / $17,100
Doctor office visit	$15	$35	$40[2]	$65[3]	0%[3]
Telehealth consultations through the select telehealth services provider[4]	$0	$0	$0[2]	$0[2]	0%[3]
Specialist	$30	$65	$80[2]	$95[3]	0%
Hospital stay	10%	20%	Facility: 20% Physician: 20%[2]	40%	0%
Outpatient surgery	10%	20%	20%[2]	40%	0%
Urgent care	$15	$35	$40[2]	$65[3]	0%[3]
Emergency care[5]	Facility: $150; Physician: $0	Facility: $350; Physician: $0	Facility: $400[2]; Physician: $0[2]	Facility: 40%; Physician: $0[2]	Facility: 0%; Physician: $0
Prescription drugs Tier 1 (most generics and low-cost preferred brands)	$5	$15	$16 Prescription drug calendar year deductible is $300 per member / $600 per family	$18/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[6]
Tier 2 (non-preferred generics and preferred brands Tier 3 (non-preferred brands only)	$15 / $25	$55 / $80	$60 / $90 Prescription drug calendar year deductible is $300 per member / $600 per family	40% up to $500/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[6]

This is a summary only. The PureCare One EPO disclosure has plan overviews with more details about what services are covered with our PureCare One EPO insurance plans. Pediatric dental and vision services are covered until the last day of the month in which the child turns age 19.

[1]Minimum coverage plans are available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this plan.

[2]Your deductible does not apply to these services.

[3]The first three visits are not subject to the deductible. You just pay the copayment. For visits 4 and more, you pay the full cost until you have paid your deductible.

[4]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[5]You do not pay the copayment if you are admitted to the hospital.

[6]Your medical deductible applies to prescription drugs for all tiers.

Important tip: To keep your costs as low as possible, go to doctors and specialists in the EnhancedCare PPO network. Doctors who aren't in your network may charge more than Health Net will pay. You may have to pay the difference between what the out-of-network doctor charges and what Health Net pays. This is called balance billing. You pay these costs in addition to your deductible, copays, coinsurance and your monthly premium. And, balance billing amounts are not covered by your plan and won't apply to your annual deductible or your out-of- pocket maximum.

EnhancedCare PPO Insurance Plans

AVAILABLE DIRECTLY THROUGH HEALTH NET

An EnhancedCare PPO is the right plan for you if freedom of choice at an affordable cost matters.

You select a primary care physician (PCP or primary doctor) from the EnhancedCare PPO network. Your PCP helps guide your care. With this plan, you can choose to get care from specialists in the network and you don't need a referral from your PCP. Because this is a tailored network, you will pay a lower premium cost. To be sure this plan is a fit for you, review the providers available in the EnhancedCare PPO provider network.

For prescription medicine, you can go to any pharmacy in the Advanced Choice Pharmacy Network. It includes CVS Pharmacy, Safeway, Costco, Vons, and others.

EnhancedCare PPO insurance plans – Your share of costs

The amounts shown here are what you would pay for the services you use with each plan. With Gold 80 EnhancedCare PPO, for example, your cost for a doctor office visit is $35.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Platinum 90 EnhancedCare PPO	Gold 80 EnhancedCare PPO	Silver 70 Off Exchange EnhancedCare PPO	Bronze 60 EnhancedCare PPO	Bronze 60 HDHP EnhancedCare PPO	Minimum Coverage EnhancedCare PPO[1]
Deductible For one person / For family	$0 / $0	$0 / $0	$4,000 / $8,000	$6,300 / $12,600	$7,000 / $14,000	$8,550 / $17,100
Out-of-pocket maximum For one person / For family	$4,500 / $9,000	$8,200 / $16,400	$8,200 / $16,400	$8,200 / $16,400	$7,000 / $14,000	$8,550 / $17,100
Doctor office visit	$15	$35	$40[2]	$65[3]	0%	0%[3]
Telehealth consultations through the select telehealth services provider[4]	$0	$0	$0[2]	$0[2]	0%	0%[3]
Specialist	$30	$65	$80[2]	$95[3]	0%	0%
Hospital stay	10%	20%	20% facility / 20% physician[2]	40%	0%	0%
Outpatient surgery	10%	20%	20%[2]	40%	0%	0%
Urgent care	$15	$35	$40[2]	$65[3]	0%	0%[3]
Emergency care[5]	Facility: $150; Physician: $0	Facility: $350; Physician: $0	Facility: $400[2]; Physician: $0[2]	Facility: 40%; Physician: $0[2]	Facility: 0%; Physician: 0%	Facility: 0%; Physician: 0%
Prescription drugs Tier 1 (most generics and low-cost preferred brands)	$5	$15	$16 Prescription drug calendar year deductible is $300 per member / $600 per family	$18/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[6]	0%[6]
Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only)	$15 / $25	$55 / $80	$60 / $90 Prescription drug calendar year deductible is $300 per member / $600 per family	40% up to $500/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[6]	0%[6]

This is a summary only. The EnhancedCare PPO disclosure has plan overviews with more details about what services are covered with our EnhancedCare PPO insurance plans. Pediatric dental and vision services are covered until the last day of the month in which the child turns age 19.

[1]Minimum coverage plans are available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this plan.

[2]Your deductible does not apply to these services.

[3]The first three visits are not subject to the deductible. You just pay the copayment. For visits 4 and more, you pay the full cost until you have paid your deductible.

[4]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[5]You do not pay the copayment if you are admitted to the hospital.

[6]Your medical deductible applies to prescription drugs for all tiers.

EnhancedCare PPO value plans and your share of costs

The amounts shown here are what you would pay for the services you use, depending on the plan you choose. With Gold Value EnhancedCare PPO, for example, your cost for a doctor office visit is $20.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Gold Value EnhancedCare PPO	Silver Value EnhancedCare PPO
Deductible For one person / For family	$1,000 / $2,000	$5,000 / $10,000
Out-of-pocket maximum For one person / For family	$8,500 / $17,000	$8,500 / $17,000
Doctor office visit[1]	$20	$45
Telehealth consultations through the select telehealth services provider[1,2]	$0	$0
Specialist[1]	$50	$60
Hospital stay	20%	30%
Outpatient surgery	20%	30%
Urgent care[1]	$20	$45
Emergency care[3]	$350 facility / $0[1] physician	$400 facility / $0[1] physician
Prescription drugs Tier 1 (most generics and low-cost preferred brands) / Tier 2 (non-preferred generics and preferred brands) / Tier 3 (non-preferred brands only)	$10[4] / $50 / $85 Prescription drug calendar year deductible is $500 per member / $1,000 per family	$15[4] / $55 / $85 Prescription drug calendar year deductible is $500 per member / $1,000 per family

This is a summary only. The EnhancedCare PPO disclosure has plan overviews with more details about what services are covered with our EnhancedCare PPO insurance plans. Pediatric dental and vision services are covered until the last day of the month in which the child turns 19 years of age.

[1]Your deductible does not apply to these services.

[2]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[3]You do not pay the copayment if you are admitted to the hospital.

[4]Your prescription drug calendar year deductible does not apply.

Full Network PPO Insurance plans

AVAILABLE DIRECTLY THROUGH HEALTH NET

Our full network PPO insurance plans give you more choice.

You can go directly to any doctor or specialist in Health Net's PPO Individual & Family provider network. You do not need referrals from a primary care physician (PCP or primary doctor).

All metal level plans (Platinum, Gold, Silver, Bronze and Minimum Coverage) are available with the these PPO plans.

Note: Out-of-state coverage is limited to emergency or urgent services.

Important tip: Use the Health Net PPO Individual & Family provider network for all covered services. Doctors who aren't in your network may charge more than Health Net will pay. You may have to pay the difference between what the out-of-network doctor charges and what Health Net pays. This is called balance billing. You pay these costs in addition to your deductible, copays, coinsurance and your monthly premium. And, balance billing amounts are not covered by your plan and won't apply to your annual deductible or your out-of-pocket maximum.

Full Network PPO plans and your share of costs

The amounts shown here are what you would pay for the services you use, depending on the plan you choose. With Gold 80 PPO, for example, your cost for a doctor visit is $30.

Reminder! Your share of costs is in addition to the monthly premium you pay for your health coverage.

Benefit	Platinum 90 PPO	Gold 80 PPO	Silver 70 PPO	Bronze 60 PPO	Minimum Coverage PPO[1]
Deductible For one person / For family	$0 / $0	$0 / $0	$4,000 / $8,000	$6,300 / $12,600	$8,550 / $17,100
Out-of-pocket maximum For one person / For family	$4,500 / $9,000	$8,200 / $16,400	$8,200 / $16,400	$8,200 / $16,400	$8,550 / $17,100
Doctor office visit	$15	$35	$40[2]	$65[3]	0%[3]
Telehealth consultations through the select telehealth services provider[4]	$0	$0	$0[3]	$0[3]	$0[3]
Specialist	$30	$65	$80[2]	$95[3]	0%
Hospital stay	10%	20%	20% facility / 20%[2] physician	40%	0%
Outpatient surgery	10%	20%	20%[2]	40%	0%
Urgent care	$15	$35	$40[2]	$65[3]	0%[3]
Emergency care[5]	$150 facility / $0 physician	$350 facility / $0 physician	$400 facility[2] / $0 physician[2]	40% facility / $0 physician[2]	0% facility / $0 physician
Prescription drugs Tier 1 (most generics and low-cost preferred brands)	$5	$15	$16 Prescription drug calendar year deductible is $300 per member / $600 per family	$18/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[7]
Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands only)	$15 / $25	$55 / $80	$60 / $90 Prescription drug calendar year deductible is $300 per member / $600 per family	40% up to $500/script Prescription drug calendar year deductible is $500 per member / $1,000 per family	0%[7]

This is a summary only. The PPO disclosure has plan overviews with more details about what services are covered with our Full Network PPO plans. Pediatric dental and vision services are covered until the last day of the month in which the child turns 19 years of age.

[1]Minimum coverage plans are available to individuals who are under age 30. You may also be eligible for this plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this plan.

[2]Your deductible does not apply to these services.

[3]You get coverage for visits 1–3 before you pay your deductible. You just pay the copayment. For visits 4 and more, you pay the full cost until you have paid your deductible.

[4]Should not replace regular doctor visits. Only telehealth services provided by a select telehealth services provider are covered at the copays shown. Covered services for medical, mental disorders and chemical dependency conditions provided appropriately as telehealth services through a regular doctor are covered on the same basis and to the same extent as covered services delivered in-person.

[5]You do not pay the copayment if you are admitted to the hospital.

[6]Your prescription drug calendar year deductible does not apply.

[7]Your medical deductible applies to prescription drugs for all tiers.

Health Care Definitions

Health coverage comes with its own language. Use our mini-glossary as you read this guide to learn more about your plan choices.

Balance billing	The difference between what the doctor charges and the amount the health plan pays. For example, if the doctor charges $250 and your plan covers $100, you pay the $150 difference. Balance billing usually applies only to plans that offer out-of-network coverage. Example: PPO plans.
Benefits (also called covered services)	The health care services that are covered by your health plan, such as office visits, X-rays, preventive care, laboratory tests, etc.
Coinsurance	Your share of the costs of a covered health care service. It is calculated as a percentage. Let's say the coinsurance is 20% and the medical bill is $100. You might pay $20, and the health plan would pay the rest.
Copayment (also called copay)	Your share of the costs of a covered health care service, set at a fixed amount. For a doctor visit that might cost $150, you would pay $15, and the health plan pays the rest. Copayments vary by plan.
Cost-sharing	The amount of money you pay out of your own pocket for services covered by your health plan. Deductibles, coinsurance and copayments are examples of cost-sharing.
Deductible	The amount you owe for some covered health care services before your health plan begins to pay for certain services. After you pay your deductible, covered services are still subject to other cost sharing like copayments and coinsurance. For example, if your deductible is $1,000, you have to pay for the health care services you use up to this amount. The deductible may not apply to all services.
Dependents	Spouse, domestic partner or children of the primary member.
Excluded services	Health care services that your health coverage doesn't pay for or cover.
Formulary	The list of prescription drugs that are covered by your health plan. Some drugs on the Essential Rx Drug List require prior authorization from Health Net in order to be covered.
Member	The person who receives benefits under the plan.
Network	The doctors, hospitals and other health care providers that your health plan has contracted with to provide health care services. The number of providers in the network varies by plan.
Out-of-pocket maximum	The most you pay during a policy period (usually a calendar year). After you pay the out-of-pocket maximum, your health plan will begin to pay 100% of the allowed amount for covered services. This limit never includes your premium or health care charges for services your health plan doesn't cover.
Premium	The amount you pay every month to maintain your health care coverage.
Preventive care	Routine health care that includes screenings, checkups and patient counseling to prevent illnesses, diseases or other health problems.
Primary care physician (PCP)	A doctor who gives or coordinates health care services for a patient. A PCP can be a medical doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).
Subscriber	The name of the primary member.
Telehealth	Health care services provided remotely by phone, mobile app, web, or other tool rather than in-person.

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/ Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/ index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ដាល់មាត់។ លោកអ្នកអាចស្ដាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada’iiyeed. Ata’ halne’ígíí da ła’ ná hádídóot’įįł. Naaltsoos da t’áá shí shizaad k’ehjí shichį’ yídooltah nínízingo t’áá ná ákódoolníił. Ákót’éego shíká a’doowoł nínízingo Customer Contact Center hoolyéhíjį’ hodíílnih ninaaltsoos nanitingo bee néého’dolzinígíí hodoonihjį’ bikáá’ éí doodago kojį’ hólne’ Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį’ hólne’ IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį’ hólne’ 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį’ hólne’ 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ ‘ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

The 2021 enrollment period begins November 1, 2020, and ends on January 31, 2021.

Call Health Net at 1-877-609-8711.

- **We will help you look at your choices.**
- **We can tell you if you can get low-cost or no-cost health coverage.**
- **We can help you sign up. We have licensed, certified, plan-based enrollers who can assist you over the phone.**

Now is the time to choose Health Net!

CLICK THE LINKS BELOW TO VIEW PLAN DISCLOSURES

CommunityCare HMO Disclosure
PureCare HSP Disclosure
PureCare One EPO Disclosure
EnhancedCare PPO Disclosure

HEALTH NET INDIVIDUAL & FAMILY PLANS

1-877-609-8711 *(English)*
1-877-891-9050 *(Cantonese)*
1-877-339-8596 *(Korean)*
1-877-891-9053 *(Mandarin)*
1-800-331-1777 *(Spanish)*
1-877-891-9051 *(Tagalog)*
1-877-339-8621 *(Vietnamese)*

ASSISTANCE FOR THE HEARING AND SPEECH IMPAIRED

TTY users call 711.

Visit us online at www.myhealthnetca.com.

BRO047426EP00 (1/21)