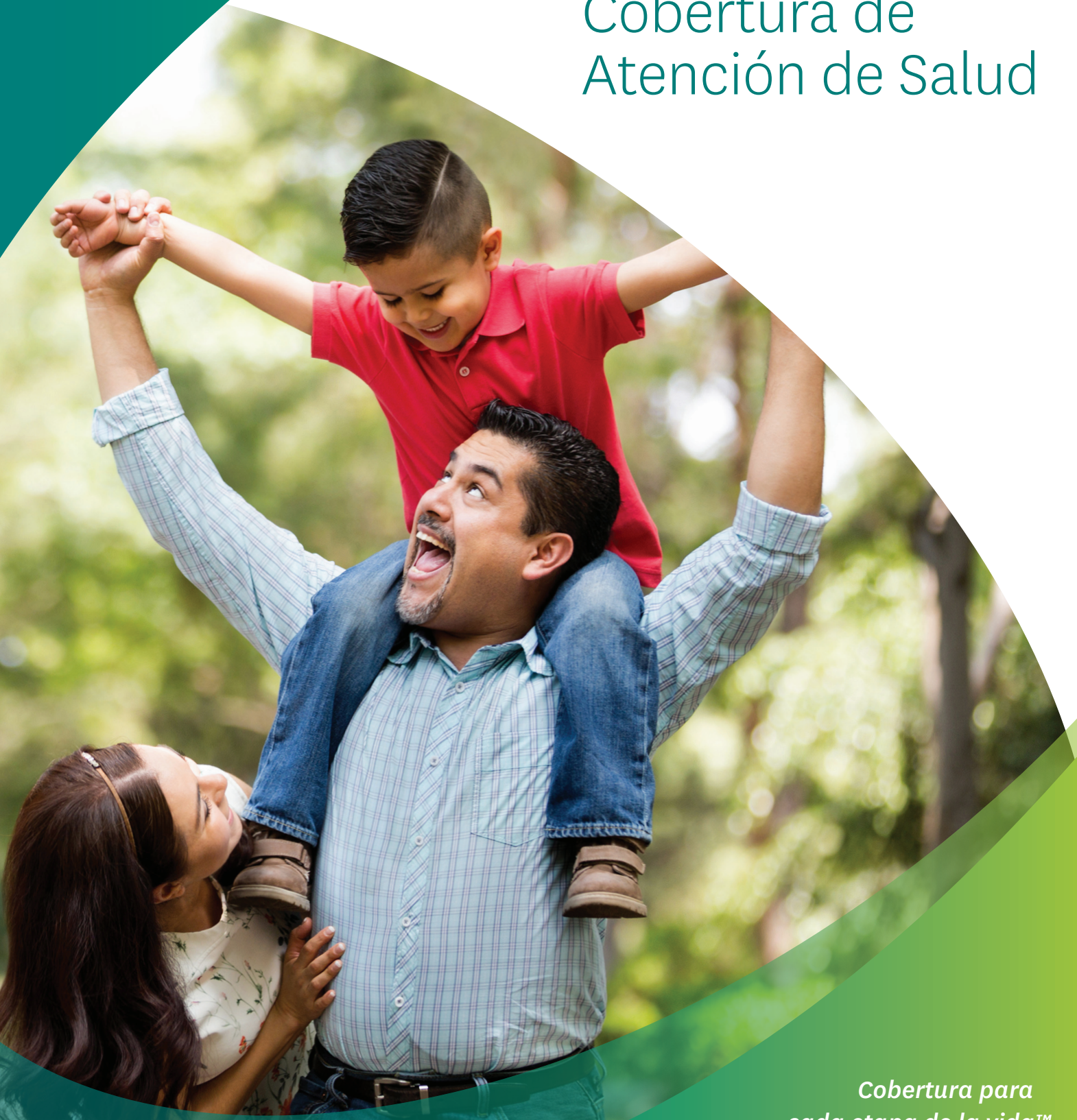
Health Net®

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

PLANES INDIVIDUALES Y FAMILIARES

Conozca Su Cobertura de Atención de Salud



Cobertura para cada etapa de la vida™

Palabras Comunes de Cobertura de la Salud

¡A veces, parece que la cobertura de la salud estuviera en su propio idioma!
Use esta lista de palabras comunes de cobertura de la salud mientras lee esta guía.

Palabra	¿Qué significa?	Ejemplo
Plan de salud o aseguradora de salud 	Organización que ofrece cobertura de la salud.	Health Net of California, Inc.
Cobertura de la salud 	También denominada "seguro de salud". Ayuda a pagar los servicios de atención de salud.	Medicare y Medi-Cal son tipos de cobertura de la salud del gobierno. Usted puede obtener cobertura de la salud privada a través de su empleo, Covered California, un plan de salud o una aseguradora de salud.
Atención administrada 	Una manera de administrar: • cuánto paga usted por la atención de salud, • cómo accede a sus beneficios y servicios de la atención de salud, y • la calidad de la atención de salud que recibe.	Los planes de salud ofrecen estos tipos de opciones de cobertura de la salud de atención administrada: Organización para el Mantenimiento de la Salud (por sus siglas en inglés, HMO) Organización de Proveedores Preferidos (por sus siglas en inglés, PPO) Organización de Proveedores Exclusivos (por sus siglas en inglés, EPO) Plan de Servicios de Atención Médica (por sus siglas en inglés, HSP)
Atención preventiva 	Servicios de atención de salud que pueden protegerle de las enfermedades y ayudarle a mantenerse saludable. No necesita estar enfermo para consultar a su médico.	• Vacuna contra la gripe • Examen de salud anual • Consejos de su médico sobre la dieta • Consejos de su médico sobre cómo prevenir los problemas de salud
Atención de rutina 	Consultas al médico para obtener la atención que necesita. Esto es muy importante si tiene afecciones como diabetes u otros problemas de salud.	Consultar a su médico: • Cuando está enfermo • Para hablar sobre una afección a largo plazo • Para hablar sobre sus medicamentos

Palabra	¿Qué significa?	Ejemplo
Médico de atención primaria (por sus siglas en inglés, PCP)	El médico principal al que consulta para obtener atención preventiva y de rutina. Por lo general, usted consultará a su PCP antes de ver a otros tipos de médicos, como un especialista. Para algunos tipos de cobertura de la salud, siempre debe ver primero a su PCP. Su PCP también puede llamarse “Proveedor Elegido” o “Proveedor de Atención Primaria”.	Un PCP realiza un examen de salud anual, le atiende cuando está enfermo y le da consejos sobre sus medicamentos y problemas de salud básicos. A veces, su PCP le remite a otros proveedores de atención de salud, como especialistas.
Especialista	Un médico al que consulta por ciertos tipos de problemas de salud. Su PCP le remitirá a especialistas si es necesario.	Hay muchos tipos de especialistas. Un cardiólogo es un especialista en el corazón y un oncólogo es un especialista en cáncer.
Red	El grupo de médicos, hospitales, clínicas, laboratorios y otros proveedores de atención de salud con los que un plan de salud acepta trabajar para brindar servicios de atención de salud.	CommunityCare HMO Network es una de las redes comunes de Health Net of California, Inc.
Remisión	Una solicitud de su médico para que usted consulte a un especialista dentro de su red. Es posible que necesite una remisión antes de poder consultar a un especialista. Probablemente su plan de salud tenga que aprobar la remisión antes de su consulta al especialista.	Remisión a un cirujano ortopédico por una lesión en la espalda.

Tener en Cuenta los Costos de Atención de Salud

Existen dos tipos de costos de atención de salud cuando usted recibe servicios de atención de salud. Estos costos dependen del tipo de cobertura de la salud que tenga.

1 **Prima**
Los costos que usted paga para tener cobertura de atención de salud.

+

2 **Costos de desembolso**
Los costos que usted paga a menudo en el momento en que usa un servicio de atención de salud.

=

Sus costos totales de atención de salud

Los costos que usted paga para tener cobertura de atención de salud

Palabra	¿Qué significa?	¿Cuándo lo pago?	Ejemplo
Prima	Un monto fijo que usted paga regularmente para obtener cobertura de la salud. Debe pagar una prima a su plan de salud para estar cubierto aunque no use los servicios de salud.	Pagos mensuales o anuales.	Si su prima es de **$480** por año, usted pagaría **$40** por mes para tener cobertura de la salud.
Costo de desembolso	Los costos, aparte de las primas, que usted paga para usar los servicios de atención de salud.	Por lo general, en el momento en que usa un servicio de atención de salud o poco después.	• Copagos • Coseguro • Deducible

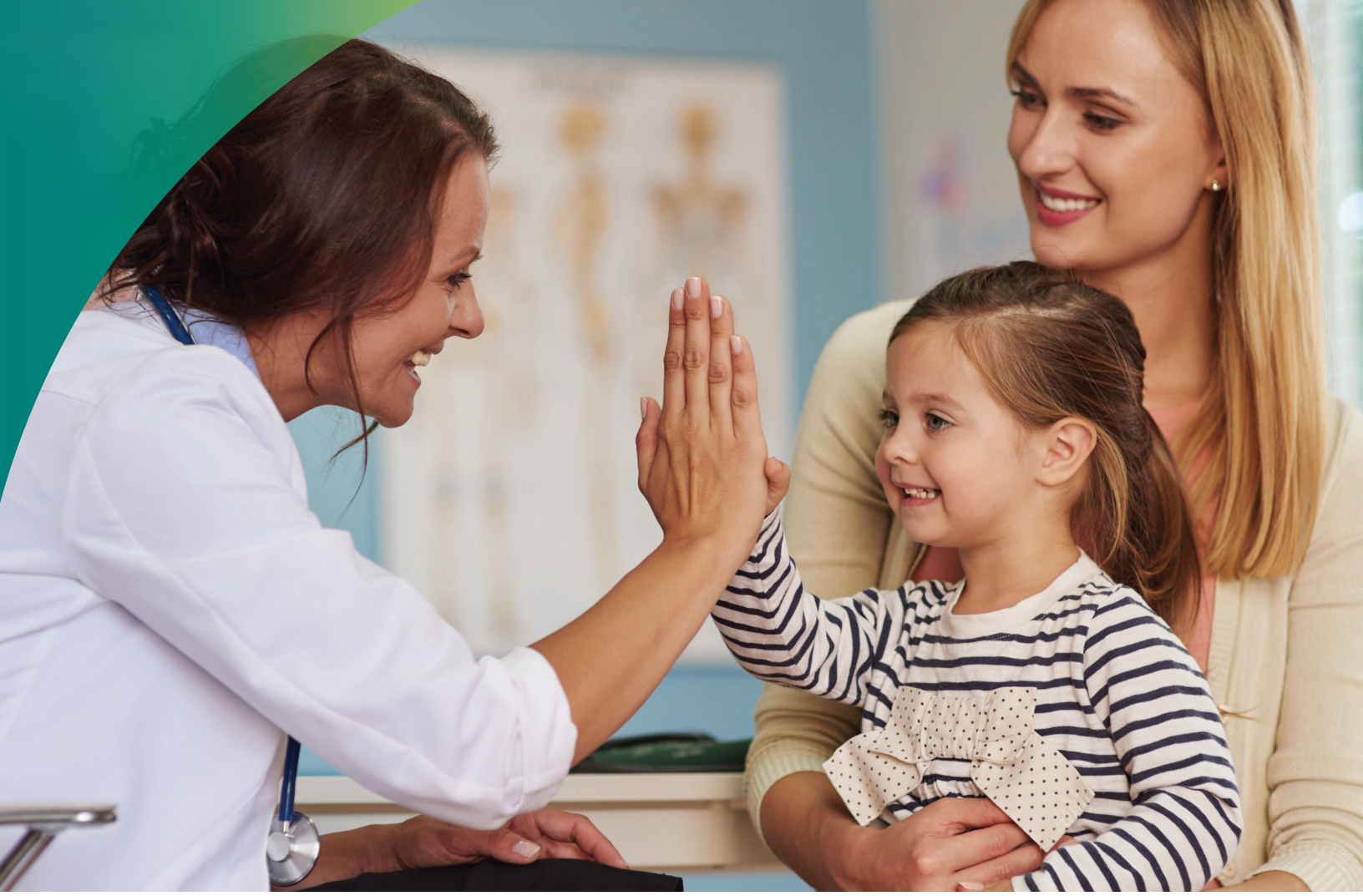
Los costos que usted paga a menudo en el momento en que usa un servicio de atención de salud

Palabra	¿Qué significa?	¿Cuándo lo pago?	Ejemplo
Copago	Un honorario fijo que usted paga por un servicio de atención de salud. Usted paga este honorario a su proveedor de atención de salud, a menudo, en el momento en que usa los servicios de atención de salud. La atención médica, de farmacia, de emergencia y otro tipo de atención de especialidades pueden tener diferentes montos de copago.	En el momento en que usa un servicio de atención de salud. La mayoría de los servicios de salud preventivos son sin cargo.	Si su copago es de **$30** por una consulta al médico habitual, usted paga **$30** cada vez que consulta a ese tipo de médico.
Coseguro	El coseguro se basa en un porcentaje del costo del servicio. Usted paga el coseguro a su proveedor de atención de salud.	Es posible que reciba una factura de parte de su proveedor de atención de salud por el monto de su coseguro.[1]	Si su coseguro es del **20%** y la factura médica es de **$100,** usted paga **$20.** El plan de salud paga el **80%,** o sea, **$80.**
Deducible	Usted paga el monto total por ciertos servicios de atención de salud hasta que haya pagado el monto de su deducible. Después de pagar su deducible, los servicios cubiertos aún están sujetos a otros costos compartidos, como copagos y coseguro.[2]	Debe pagar el monto de su deducible a sus proveedores de atención de salud durante el año cada vez que use los servicios.[3]	Si su deducible es de **$1,000,** usted debe pagar **$1,000** en costos de atención de salud a sus proveedores de atención de salud durante el año antes de poder usar los servicios de atención de salud por un copago o coseguro.
Desembolso máximo	El desembolso máximo puede incluir copagos, coseguro y deducibles. Este límite nunca incluye su prima ni los costos de los servicios de atención de salud que no cubre su plan de salud. Una vez que usted alcance su desembolso máximo correspondiente al año del plan, su plan de salud pagará el 100% de sus costos de atención de salud cubiertos durante el año del plan restante.	Usted pagará sus copagos, su coseguro y sus deducibles durante el año hasta alcanzar el monto de desembolso máximo de su plan. Esto es lo máximo que pagará usted en costos de atención de salud para el año de cobertura.	Si su desembolso máximo es de **$5,000,** lo máximo que usted pagará por los servicios cubiertos cada año es **$5,000** en copagos, coseguro y deducibles.

[1]Para el coseguro, a veces usted paga todo el costo del servicio de atención de salud en el momento en que consulta a un proveedor de atención de salud. Luego, usted envía el recibo a su plan de salud. Su plan de salud le devuelve la parte que le corresponde de los costos de atención de salud.

[2]Algunos tipos de cobertura de la salud no tienen deducible.

[3]Usted siempre debe leer el contrato de cobertura de su plan de salud, a veces llamado *Evidencia de Cobertura*, para conocer cómo se alcanza su deducible.



Qué Obtiene Usted con la Atención Médica Administrada

También puede obtener servicios que le ayuden a hablar con su médico en su propio idioma.

- **Acceso a atención de calidad** – Usted obtiene atención de salud de calidad de parte de una red de médicos. Su médico trabaja estrechamente con usted para brindarle las opciones correctas de cuidado y tratamiento. Además, usted obtiene información útil sobre sus derechos y responsabilidades como afiliado a un plan de salud.
- **Un plan de salud que está aquí para ayudar**
  - Su plan de salud está aquí para asegurarse de que usted obtenga el cuidado adecuado —donde y cuando lo necesite—.
  - Su plan de salud puede ayudarle a programar una cita, cambiar de médico y responder preguntas sobre su factura.
  - Si está enfermo o necesita consejos sobre salud, puede hablar con una enfermera por teléfono y a veces en línea. Las enfermeras que brindan consejos pueden recomendarle cómo ocuparse de las lesiones y enfermedades y cómo prepararse para las consultas con el médico.
- **Beneficios y servicios para ayudarle a mantenerse saludable** – Éstos pueden incluir:
  - Apoyo para ayudarle a dejar de fumar.
  - Clases de educación sobre la salud.
  - Programas que le ayuden a comer alimentos saludables y estar más activo.

Elija una Cobertura de la Salud Que se Adapte a Su Vida

Los planes de salud trabajan con redes de proveedores de atención de salud para que usted pueda obtener atención de salud a costos fijos. Los planes de salud ofrecen diferentes tipos de cobertura según sus necesidades de salud y su presupuesto. Usted obtiene ahorros en los costos si recibe atención de salud dentro de la red de médicos y proveedores de un plan de salud.

HMO

Organización para el Mantenimiento de la Salud (HMO)

Un plan de HMO es un tipo de cobertura de la salud que ofrece acceso a la atención de salud a través de una red de proveedores de atención de salud. Una red es un grupo fijo de médicos, hospitales, clínicas, laboratorios y farmacias. Usted elige un médico de atención primaria (por sus siglas en inglés, PCP) de su red, que coordinará su atención y le remitirá a especialistas dentro de la red, según sea necesario.

¿Por qué elegir un plan de HMO?

- **Usted confía en su PCP para que supervise su atención y le remita a especialistas según sea necesario.**
- **Menos documentación para usted.**
- **Menores costos de desembolso.**

Opciones de dónde y cómo obtiene atención: el ejemplo de Health Net CommunityCare HMO

Consulte a su PCP: el médico principal que usted elige de la Red CommunityCare HMO. Usted consulta a su PCP cuando necesita recibir cuidado y obtener remisiones a especialistas.

Use la Red CommunityCare HMO para todos los servicios cubiertos. Si necesita un especialista, su PCP le proporcionará una remisión.

No hay cobertura para servicios fuera de la red, excepto para atención de emergencia, atención de urgencia y servicios aprobados por Health Net.

Use los servicios de telesalud de Teladoc por teléfono, en video o a través de la aplicación. Use Teladoc cuando el consultorio de su médico está cerrado o usted necesita acceso rápido a servicios de atención de salud.

Los proveedores de Teladoc pueden tratar muchas enfermedades frecuentes, como problemas sinusales, infecciones en las vías respiratorias superiores, alergias, bronquitis y conjuntivitis.

Hable con personal de enfermería titulado por teléfono las 24 horas del día/los 7 días de la semana para obtener consejos sobre cómo manejar inquietudes de salud urgentes, y tratar lesiones menores y enfermedades como fiebre y la gripe.

Use un centro de atención de urgencia cuando necesita tratamiento de inmediato para problemas como esguinces leves, dolor de oído, resfríos o dolor de espalda.

Vaya inmediatamente a la sala de emergencias más cercana o llame al 911 en caso de emergencia.

PPO

Organización de Proveedores Preferidos (PPO)

Un plan de PPO también es un tipo de cobertura de la salud con una red fija de proveedores de atención de salud. Puede consultar a proveedores fuera de la red, pero es probable que pague más. También puede ir a un especialista sin obtener una remisión. **Nota:** La cobertura fuera del estado se limita a servicios de emergencia o de urgencia.

¿Por qué elegir un plan de PPO?

- **Desea más opciones de médicos y hospitales.**
- **Prefiere la flexibilidad de elegir especialistas, cuando sea necesario, para satisfacer sus necesidades de atención de salud.**
- **Desea administrar su propia atención de salud sin consultar primero a su PCP.**

Opciones de dónde y cómo obtiene atención: el ejemplo de Health Net PPO[4]

Vaya directamente a cualquier médico o especialista dentro de la Red de Planes Individuales y Familiares PPO para recibir atención.

La red incluye todos los especialistas que usted pueda necesitar para su salud: desde cardiólogos hasta dermatólogos.

Programe una consulta con un médico de Heal para "visitas a domicilio" de atención primaria, preventiva y de urgencia. Un médico de Heal le visitará en su hogar, oficina u hotel, de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Disponible mediante citas en determinadas áreas urbanas.

Use los servicios de telesalud de Teladoc por teléfono, en video o a través de la aplicación. Use Teladoc cuando el consultorio de su médico está cerrado o usted necesita acceso rápido a servicios de atención de salud.

Los proveedores de Teladoc pueden tratar muchas enfermedades frecuentes, como problemas sinusales, infecciones en las vías respiratorias superiores, alergias, bronquitis y conjuntivitis.

Hable con personal de enfermería titulado por teléfono las 24 horas del día/los 7 días de la semana para obtener consejos sobre cómo manejar inquietudes de salud urgentes, y tratar lesiones menores y enfermedades como fiebre y la gripe.

Visite una clínica para pacientes sin cita previa, como una MinuteClinic (disponible en determinadas farmacias CVS), donde puede obtener atención para enfermedades frecuentes, evaluaciones de bienestar, vacunas y más.

Use un centro de atención de urgencia cuando necesita tratamiento de inmediato para problemas como esguinces leves, dolor de oído, resfríos o dolor de espalda.

Vaya inmediatamente a la sala de emergencias más cercana o llame al 911 en caso de emergencia.

Vaya a cualquier proveedor de atención de salud fuera de la red si lo desea. Pagará más como costo de desembolso cuando lo haga.

[4]Estas opciones de atención corresponden al producto individual de Health Net, la Red PPO Completa. La red adaptada a las necesidades EnhancedCare PPO de Health Net también está disponible en algunas regiones.

EPO

Organización de Proveedores Exclusivos (EPO)

Un plan de EPO es un tipo de cobertura de la salud que también cuenta con una red de proveedores de atención de salud. Al igual que en un plan de HMO, usted debe usar los proveedores de atención de salud dentro de su red. Usted debe elegir a un PCP, pero puede consultar a un especialista sin necesidad de ver primero a su PCP. Sólo puede consultar a especialistas dentro de la Red PureCare One EPO.

¿Por qué elegir un plan de EPO?

- **Desea más opciones de médicos y hospitales, pero no quiere pagar el costo más alto de un plan de PPO.**
- **Desea consultar a un especialista sin necesidad de una remisión.**
- **Desea administrar su propia atención de salud sin consultar primero a su PCP.**

Opciones de dónde y cómo obtiene atención: el ejemplo de Health Net PureCare One EPO

Consulte a su PCP: el médico principal que usted elige de la Red PureCare One EPO.

Vaya directamente a cualquier médico o especialista dentro de la Red PureCare One EPO para recibir atención. No necesita consultar primero a su PCP ni obtener remisiones.

No hay cobertura para servicios fuera de la red, excepto para atención de emergencia, atención de urgencia y servicios aprobados por Health Net.

Programe una consulta con un médico de Heal para "visitas a domicilio" de atención primaria, preventiva y de urgencia. Un médico de Heal le visitará en su hogar, oficina u hotel, de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Disponible mediante citas en determinadas áreas urbanas.

Use los servicios de telesalud de Teladoc por teléfono, en video o a través de la aplicación. Use Teladoc cuando el consultorio de su médico está cerrado o usted necesita acceso rápido a servicios de atención de salud.

Los proveedores de Teladoc pueden tratar muchas enfermedades frecuentes, como problemas sinusales, infecciones en las vías respiratorias superiores, alergias, bronquitis y conjuntivitis.

Visite una clínica para pacientes sin cita previa, como una MinuteClinic (disponible en determinadas farmacias CVS), donde puede obtener atención para enfermedades frecuentes, evaluaciones de bienestar, vacunas y más.

Hable con personal de enfermería titulado por teléfono las 24 horas del día/los 7 días de la semana para obtener consejos sobre cómo manejar inquietudes de salud urgentes, y tratar lesiones menores y enfermedades como fiebre y la gripe.

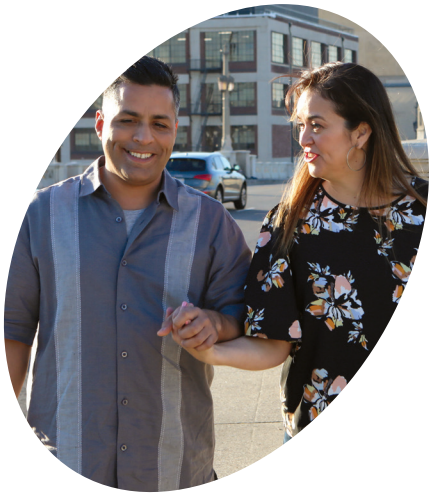
Use un centro de atención de urgencia cuando necesita tratamiento de inmediato para problemas como esguinces leves, dolor de oído, resfríos o dolor de espalda.

Vaya inmediatamente a la sala de emergencias más cercana o llame al 911 en caso de emergencia.

HSP

Plan de Servicios de Atención de Salud (HSP)

Un plan de HSP es un tipo de cobertura de la salud como un plan de HMO. Usted debe elegir a un PCP, pero puede consultar a un especialista sin necesidad de ver primero a su PCP. Sólo puede consultar a especialistas dentro de la Red PureCare HSP.



¿Por qué elegir un plan de HSP?

- **Usted confía en su PCP para que supervise su atención.**
- **Desea consultar a un especialista sin necesidad de una remisión.**

Opciones de dónde y cómo obtiene atención: el ejemplo de Health Net PureCare HSP

Consulte a su PCP: el médico principal que usted elige de la Red PureCare HSP.

Vaya directamente a cualquier médico o especialista dentro de la Red PureCare HSP para recibir atención. No necesita consultar primero a su PCP ni obtener remisiones.

No hay cobertura para servicios fuera de la red, excepto para atención de emergencia, atención de urgencia y servicios aprobados por Health Net.

Use los servicios de telesalud de Teladoc por teléfono, en video o a través de la aplicación. Use Teladoc cuando el consultorio de su médico está cerrado o usted necesita acceso rápido a servicios de atención de salud.

Los proveedores de Teladoc pueden tratar muchas enfermedades frecuentes, como problemas sinusales, infecciones en las vías respiratorias superiores, alergias, bronquitis y conjuntivitis.

Hable con personal de enfermería titulado por teléfono las 24 horas del día/los 7 días de la semana para obtener consejos sobre cómo manejar inquietudes de salud urgentes, y tratar lesiones menores y enfermedades como fiebre y la gripe.

Visite una clínica para pacientes sin cita previa, como una MinuteClinic (disponible en determinadas farmacias CVS), donde puede obtener atención para enfermedades frecuentes, evaluaciones de bienestar, vacunas y más.

Use un centro de atención de urgencia cuando necesita tratamiento de inmediato para problemas como esguinces leves, dolor de oído, resfríos o dolor de espalda.

Vaya inmediatamente a la sala de emergencias más cercana o llame al 911 en caso de emergencia.

Si desea obtener más información sobre los planes de salud de atención administrada disponibles de Health Net, visite **www.myhealthnetca.com.**

Esta información tiene el objetivo de ayudar a las personas a conocer los puntos básicos de la atención médica administrada. Es posible que algunas de las palabras de este folleto no se apliquen a su cobertura de la salud o que se usen de manera diferente. Consulte con su plan de salud para obtener más información sobre sus beneficios de cuidado de la salud. Consulte su *Contrato del Plan* y *Evidencia de Cobertura* (HMO y HSP), o bien, su Póliza (PPO y EPO) para conocer los términos y condiciones de cobertura.

Para los afiliados a Health Net

Para conocer más sobre sus beneficios de atención de salud, llame al número del Departamento de Servicios al Afiliado que aparece en su tarjeta de identificación de afiliado o visite www.myhealthnetca.com.

Visite nuestro sitio Web en www.myhealthnetca.com

Centro de Comunicación con el Cliente: **1-888-926-4988**

Ventas e inscripción: **1-877-527-8409**

Pago automático: **1-800-539-4193**

Ayuda para usar nuestro sitio Web: **1-866-458-1047**

BKT000837SO03 (2/20)

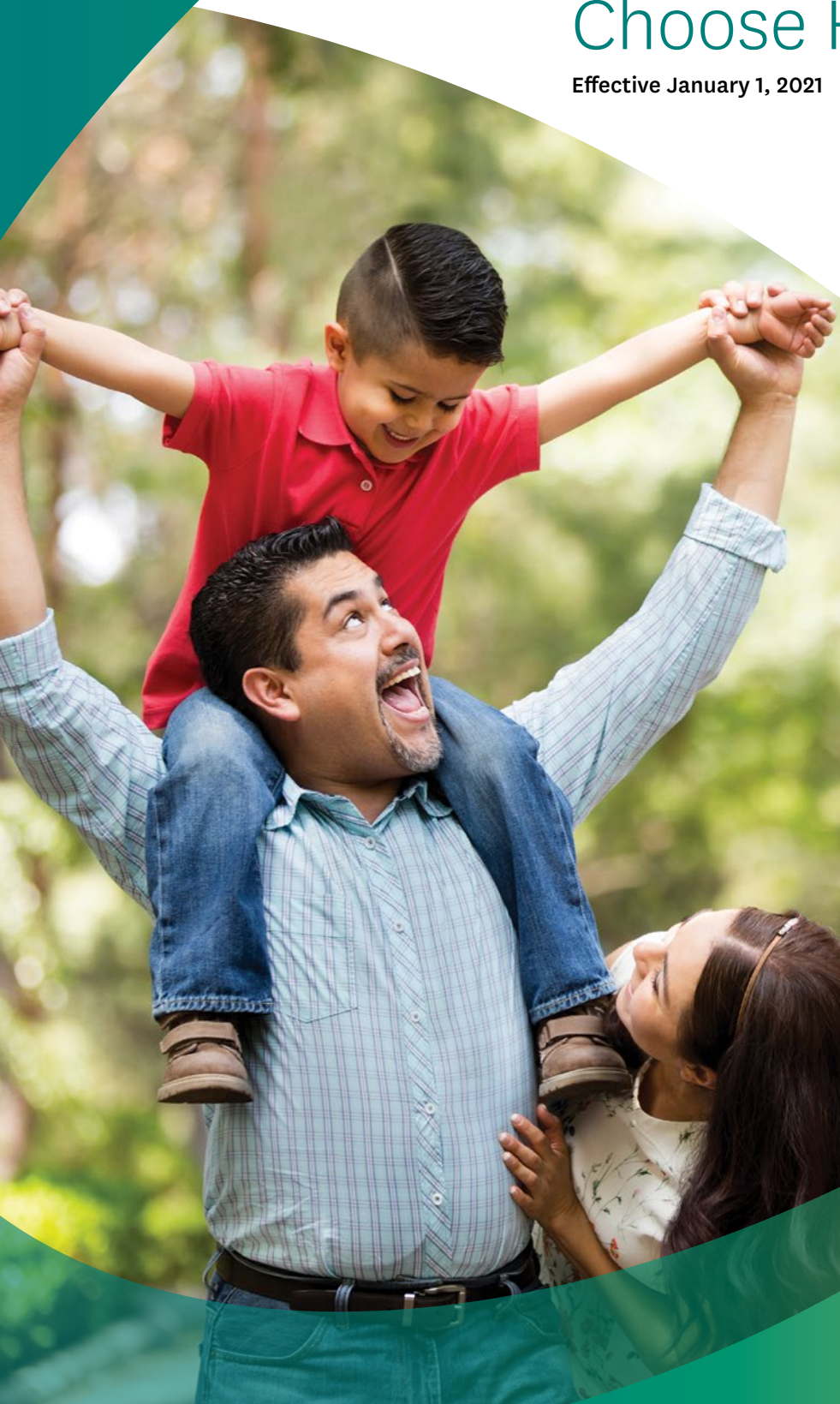
Health Net®

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

INDIVIDUAL & FAMILY PLANS
AVAILABLE THROUGH COVERED CALIFORNIA™

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 our plans through Covered California.*

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.
- You may be able to get help paying your premium. Premium assistance through California and the federal government is available based on your family household income. Financial help is only available when you buy health coverage through Covered California.
- 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.

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.CoveredCA.com**.
- **Visit** your local broker or a Covered California certified enrollment counselor.

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?
- ☑ Do you qualify to get premium assistance?

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 20 if you are confused about a health care word.

Financial Help through Covered California

The government offers financial help for health coverage to people who qualify. There are two types of help:

You have to buy health coverage through Covered California to get premium assistance and/or cost-sharing reductions.

Premium assistance

for people who qualify lowers the cost you pay every month for health care coverage.

Cost-sharing reductions

available on Enhanced Silver plans lower what you pay for services like doctor visits.

Both kinds of help are based on your annual household income and family size.

Premium assistance is available, if you qualify, for all plans except Minimum Coverage plans.

Cost-sharing reductions are available with silver level plans that are called Enhanced Silver plans.

You can find out what premium you will pay based on your age, ZIP code, income, and the number of people in your family.

Call Health Net at **1-877-609-8711**, and we will help you find the coverage level that fits you best.

You can also use Covered California's online Shop and Compare tool at **www.CoveredCA.com** to do this.

Here is an example:

Kate is 40 years old and buying health care for herself and her three kids. Because she makes about $45,000 a year, she qualifies for both premium assistance and cost-sharing reductions.

First, premium assistance will lower the amount she has to pay each month for coverage. The premium assistance is available no matter what metal level plan she chooses.

Second, she can get an Enhanced Silver plan that lowers the amount she pays for doctor visits and other services.

For example, Kate's copayment for a doctor visit might be $15 instead of $40.

With three kids, Kate's family sees the doctor fairly often. So Kate decides that an Enhanced Silver-level plan is right for her.

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!

You can enroll in a Health Net plan through Covered California.

If you need help, we're here to answer your questions and help you choose a plan. Just call 1-877-609-8711.

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

Covered California – 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
Contra Costa	5			✔	
Kern County[3]	14	✔	✔		
Los Angeles	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 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

THROUGH COVERED CALIFORNIA

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

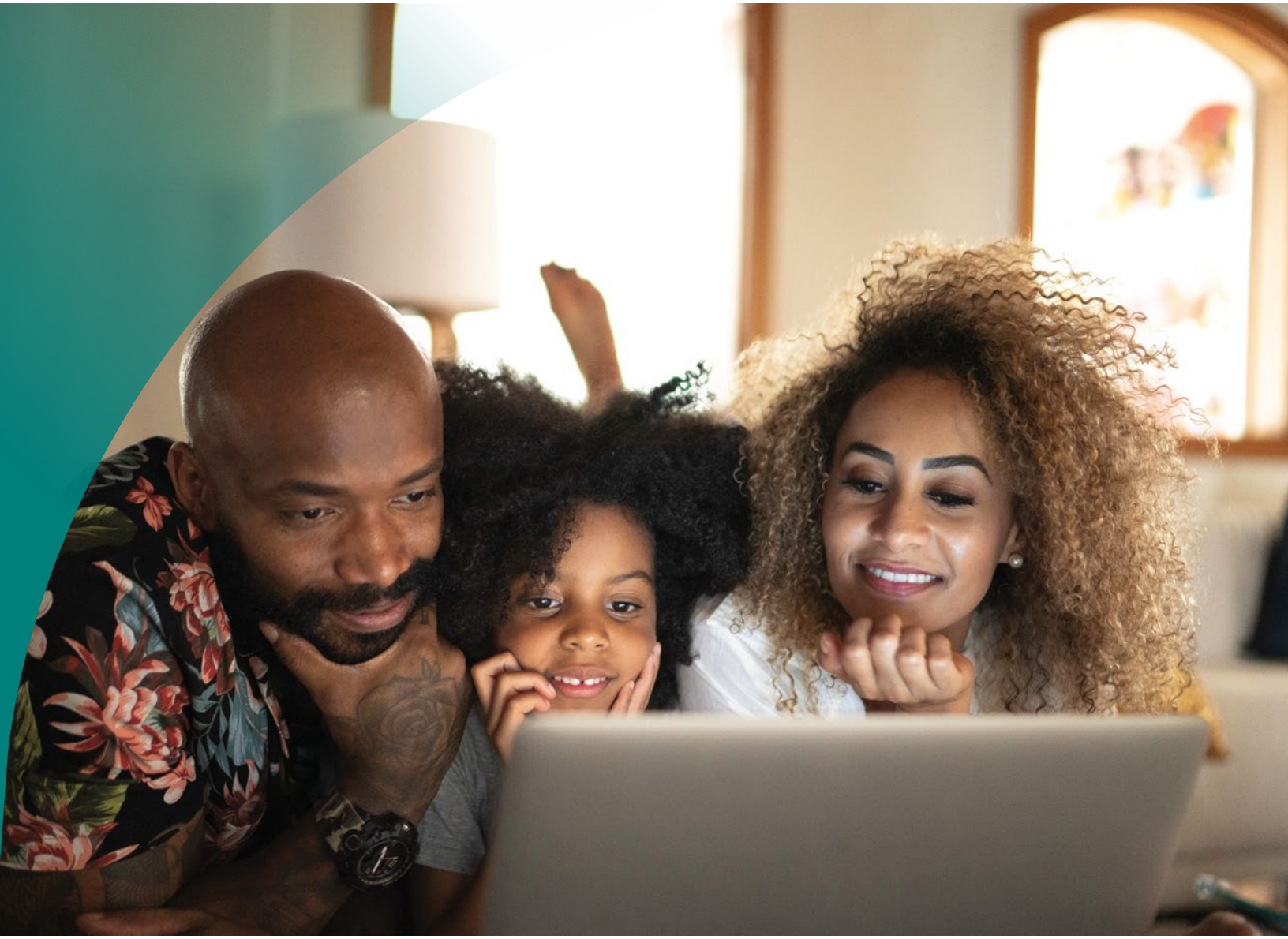
- *More predictable costs, and*
- *One familiar doctor to oversee your care*

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.

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.



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 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.

CommunityCare HMO Enhanced Silver plans – Your share of costs

Some people qualify for extra help paying for their health services. These plans have cost-sharing reductions. Instead of paying $40 to visit the doctor, the cost could be as low as $5. The extra help comes with silver-level plans that are called Enhanced Silver. People with an income between 138 percent and 250 percent of the federal poverty level qualify for Enhanced Silver.

Benefit	Silver 94 CommunityCare HMO	Silver 87 CommunityCare HMO	Silver 73 CommunityCare HMO
Deductible For one person / For family	$75 / $150	$1,400 / $2,800	$3,700 / $7,400
Out-of-pocket maximum For one person / For family	$1,000 / $2,000	$2,850 / $5,700	$6,500 / $13,000
Doctor office visit[1]	$5	$15	$35
Telehealth consultations through the select telehealth services provider[1,2]	$0	$0	$0
Specialist[1]	$8	$25	$75
Hospital stay	Facility: 10%; Physician: 10%[1]	Facility: 15%; Physician: 15%[1]	Facility: 20%; Physician: 20%[1]
Outpatient surgery[1]	10%	15%	20%
Urgent care[1]	$5	$15	$35
Emergency care[1,3]	Facility: $50; Physician: $0	Facility: $150; Physician: $0	Facility: $400; Physician: $0
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)	$3 / $10 / $15	$5[4] / $25 / $45 Prescription drug calendar year deductible is $100 per member / $200 per family	$16 / $55 / $85 Prescription drug calendar year deductible is $275 per member / $550 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]You do not pay the copayment if you are admitted to the hospital.

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

PureCare HSP Plans

THROUGH COVERED CALIFORNIA

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

THROUGH COVERED CALIFORNIA

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 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.

PureCare One EPO Enhanced Silver plans – Your share of costs

Some people qualify for extra help paying for their health services. These plans have cost-sharing reductions. Instead of paying $40 to visit the doctor, the cost could be as low as $5. The extra help comes with silver-level plans that are called Enhanced Silver. Individuals with an income between 138 percent and 250 percent of the federal poverty level qualify for Enhanced Silver.

Benefit	Silver 94 PureCare One EPO	Silver 87 PureCare One EPO	Silver 73 PureCare One EPO
Deductible For one person / For family	$75 / $150	$1,400 / $2,800	$3,700 / $7,400
Out-of-pocket maximum For one person / For family	$1,000 / $2,000	$2,850 / $5,700	$6,500 / $13,000
Doctor office visit[1]	$5	$15	$35
Telehealth consultations through the select telehealth services provider[1,2]	$0	$0	$0
Specialist[1]	$8	$25	$75
Hospital stay	Facility: 10%; Physician: 10%[1]	Facility: 15%; Physician: 15%[1]	Facility: 20%; Physician: 20%[1]
Outpatient surgery[1]	10%	15%	20%
Urgent care[1]	$5	$15	$35
Emergency care[1,3]	Facility: $50; Physician: $0	Facility: $150; Physician: $0	Facility: $400; Physician: $0
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)	$3[1] / $10[1] / $15[1]	$5[4] / $25 / $45 Prescription drug calendar year deductible is $100 per member / $200 per family	$16 / $55 / $85 Prescription drug calendar year deductible is $275 per member / $550 per family

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. 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 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.

EnhancedCare PPO Insurance Plans

THROUGH COVERED CALIFORNIA

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.

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 – 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 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 Enhanced Silver plans – Your share of costs

Some people qualify for extra help paying for their health services. These plans have cost-sharing reductions. Instead of paying $40 to visit the doctor, the cost could be as low as $5. The extra help comes with silver-level plans that are called Enhanced Silver. Individuals with an income between 138 percent and 250 percent of the federal poverty level qualify for Enhanced Silver.

Benefit	Silver 94 EnhancedCare PPO	Silver 87 EnhancedCare PPO	Silver 73 EnhancedCare PPO
Deductible For one person / For family	$75 / $150	$1,400 / $2,800	$3,700 / $7,400
Out-of-pocket maximum For one person / For family	$1,000 / $2,000	$2,850 / $5,700	$6,500 / $13,000
Doctor office visit[1]	$5	$15	$35
Telehealth consultations through the select telehealth services provider[1,2]	$0	$0	$0
Specialist[1]	$8	$25	$75
Hospital stay	Facility: 10%; Physician: 10%[1]	Facility: 15%; Physician: 15%[1]	Facility: 20%; Physician: 20%[1]
Outpatient surgery[1]	10%	15%	20%
Urgent care[1]	$5	$15	$35
Emergency care[1,3]	Facility: $50; Physician: $0	Facility: $150; Physician: $0	Facility: $400; Physician: $0
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)	$3[1] / $10[1] / $15[1]	$5[4] / $25 / $45 Prescription drug calendar year deductible is $100 per member / $200 per family	$16 / $55 / $85 Prescription drug calendar year deductible is $275 per member / $550 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 age 19.

[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.

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។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ 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.

Health Net® | COVERED CALIFORNIA™

BRO044896EO00 (1/21)

2021

Health Net®

Got Questions?

CALL US FOR ANSWERS!

Whether you're looking for more info about enrollment, how to make a payment, or what is covered under your plan, Health Net is here to help. With the chart below, you'll find help through live representatives, walk-through instructions and online resources. You have questions – we have answers!

What you need	Where to find help	Hours of operation
Enroll with Health Net or change plans	**Sales and Enrollment** 1-877-527-8409	8 a.m. to 6 p.m., Monday through Friday.
Find answers about your coverage	**Customer Contact Center** If you enrolled through Covered California, call: 1-888-926-4988 (TTY: 711) If you enrolled directly through Health Net, call: 1-800-839-2172 (TTY: 711)	8 a.m. to 6 p.m., Monday through Friday. 8 a.m. to 5 p.m., on Saturday. **During Open Enrollment:** 8 a.m. to 8 p.m., Monday through Friday. 8 a.m. to 6 p.m., on Saturday.
Make a payment	Pay online: www.myhealthnetca.com	24 hours a day, 7 days a week.
	Pay by phone: 1-800-539-4193, automated system, or you can call the Customer Contact Center (see above).	24 hours a day, 7 days a week.
	Pay by mail: Mail a check or money order made payable to "Health Net" along with your payment coupon to: Health Net CA Individual PO Box 748705, Los Angeles, CA 90074-8705	Anytime the U.S. Postal Service is open.
	Pay with MoneyGram:® Find a MoneyGram location near you. Visit www.moneygram.com/us/en/how-to-pay-bills or call 1-800-926-9400. Receive Code: 16375	Specific hours of operation may vary per location. Please contact the location for more information.
More ways to access care	**Heal – in-home health service** 1-844-644-4325 or visit www.heal.com/healthnet.com.	8 a.m. to 8 p.m., Monday through Sunday.
	Babylon – telehealth services Download the Babylon app in the Apple App Store or Google Play. Use member code: HNCOM	24 hours a day, 7 days a week.
Help with our website	**Technical support for www.myhealthnetca.com** 1-866-458-1047	8:30 a.m. to 5:30 p.m., Monday through Friday.
Info about State Health Programs (Medi-Cal)	**Health Net** 1-800-327-0502 **CalViva Health for Fresno, Kings and Madera counties** 1-877-618-0903 **East Los Angeles Community Resource Center** (323) 415-9120 or 1-877-698-7662	7:30 a.m. to 7 p.m., Monday through Friday.
Info out about Medicare options	**Medicare Advantage plans** Jade, Sapphire, Amber, and HMO SNP 1-800-431-9007 (TTY: 711) **All other HMOs** 1-800-275-4737 (TTY: 711)	**From February 15 to September 30** 8 a.m. to 8 p.m., Monday through Friday. **From October 1 to February 14** 8 a.m. to 8 p.m., 7 days a week. A messaging system is used after hours, weekends and on federal holidays.
	Medicare Supplement plans 1-800-944-7287 (TTY: 711)	8 a.m. to 6 p.m., Monday through Friday (excluding holidays).
Find our Community Resource Center	Health Net Community Resource Center 5047 East Whittier Blvd., East Los Angeles, CA 90022 (323) 415-9120 or 1-877-698-7662	8 a.m. to 4:30 p.m., Monday through Friday.

FLY045336EH00 (8/20)

2021

¿Tiene Preguntas?

¡LLÁMENOS PARA OBTENER RESPUESTAS!

Ya sea que esté buscando más información sobre la inscripción, cómo efectuar un pago o qué está cubierto por su plan, Health Net está aquí para ayudar. En el cuadro a continuación, encontrará ayuda a través de representantes en directo, instrucciones paso a paso y recursos en línea. ¡Usted tiene preguntas – nosotros tenemos respuestas!

Qué necesita	Dónde encontrar ayuda	Horario de atención
Inscribirse en Health Net o cambiarse de plan	**Ventas e Inscripción** 1-877-527-8409	De lunes a viernes, de 8:00 a.m. a 6:00 p.m.
Encontrar respuestas sobre su cobertura	**Centro de Comunicación con el Cliente** Si se inscribió a través de Covered California, llame al: 1-888-926-4988 (TTY: 711) Si se inscribió directamente a través de Health Net, llame al: 1-800-839-2172 (TTY: 711)	De lunes a viernes, de 8:00 a.m. a 6:00 p.m., los sábados de 8:00 a.m. a 5:00 p.m. **Durante la Inscripción Abierta:** De lunes a viernes, de 8:00 a.m. a 8:00 p.m., los sábados de 8:00 a.m. a 6:00 p.m.
Efectuar un pago	Pagar en línea: www.myhealthnetca.com	Las 24 horas del día, los 7 días de la semana.
	Pagar por teléfono: 1-800-539-4193, sistema automático, o puede llamar al Centro de Comunicación con el Cliente (consulte más arriba).	Las 24 horas del día, los 7 días de la semana.
	Pagar por correo: Envíe un cheque o giro postal a nombre de "Health Net" junto con su cupón de pago a: Health Net CA Individual PO Box 748705, Los Angeles, CA 90074-8705	Siempre que esté abierto el Servicio Postal de los EE. UU.
	Pagar con MoneyGram®: Encuentre una ubicación de MoneyGram cerca de usted. Visite www.moneygram.com/us/en/how-to-pay-bills o llame al 1-800-926-9400. Código de Recepción: 16375	El horario de atención específico puede variar según la ubicación. Comuníquese con la ubicación para obtener más información.
Más maneras de acceder a la atención	**Heal – servicio de cuidado de la salud en el hogar** 1-844-644-4325 o visite www.heal.com/healthnet.com.	De lunes a domingos, de 8:00 a.m. a 8:00 p.m.
	Babylon – servicios de telesalud Descargue la aplicación Babylon en la App Store de Apple o Google Play. Use el código de afiliado: HNCOM	Las 24 horas del día, los 7 días de la semana.
Ayuda con nuestro sitio Web	**Soporte técnico de www.myhealthnetca.com** 1-866-458-1047	De lunes a viernes, de 8:30 a.m. a 5:30 p.m.
Información sobre los Programas de Salud Estatales (Medi-Cal)	**Health Net** 1-800-327-0502 **CalViva Health para los condados de Fresno, Kings y Madera** 1-877-618-0903 **Centro de Recursos Comunitarios de East Los Angeles** (323) 415-9120 o 1-877-698-7662	De lunes a viernes, de 7:30 a.m. a 7:00 p.m.
Información sobre las opciones de Medicare	**Planes Medicare Advantage** Planes Jade, Sapphire, Amber y de HMO SNP 1-800-431-9007 (TTY: 711) **Todos los demás planes de HMO** 1-800-275-4737 (TTY: 711)	**Del 15 de febrero al 30 de septiembre** lunes a viernes, de 8:00 a.m. a 8:00 p.m. **Del 1 de octubre al 14 de febrero** de 8:00 a.m. a 8:00 p.m., los 7 días de la semana. Después del horario de atención, los fines de semana y los días feriados federales, se utiliza un sistema de mensajería.
	Planes Suplementarios de Medicare 1-800-944-7287 (TTY: 711)	De lunes a viernes, de 8:00 a.m. a 6:00 p.m., excepto los días feriados.
Encontrar nuestro Centro de Recursos Comunitarios	Health Net Community Resource Center 5047 East Whittier Blvd., East Los Angeles, CA 90022 (323) 415-9120 o 1-877-698-7662	De lunes a viernes, de 8:00 a.m. a 4:30 p.m.

FLY047579SH00 (8/20)