Individual & Family
EPO Insurance Plans

Available through Covered California

For coverage, go to www.coveredca.com to apply today!

Health Net®

Outline of Coverage and Exclusions and Limitations

Plans available through Covered California in Northern and Central California[1]

Health Net Life Insurance Company Individual & Family Health Insurance Plans major medical expense coverage.

Read your Policy carefully

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

[1]Health Net Life Insurance Company EPO plans utilize the PureCare One provider network. Offered in Contra Costa, Kern, Marin, Merced, Napa, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, and Tulare counties.

Plan Overview – Health Net Platinum 90 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$0
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$4,000 single / $8,000 family
Professional services Office visit copay	$20
Specialist visit	$40
Other practitioner office visit (including medically necessary acupuncture)	$20
Preventive care services[5]	$0
X-ray and diagnostic imaging	$40
Laboratory tests	$20
Imaging (CT/PET scans, MRIs)	10%
Rehabilitation and habilitation services	$20
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	10%
Hospital services Inpatient hospital stay (includes maternity)	10%
Skilled nursing care	10%
Emergency services Emergency room services (copayment waived if admitted)	$150
Urgent care	$40
Ambulance services (ground and air)	$150
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	10%
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$20
Home health care services (100 visits per calendar-year)	10%
Other services Durable medical equipment	10%
Hospice service	$0
Self-injectables (other than insulin)	10%
Prescription drug coverage Brand-name calendar-year deductible	N/A
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 generic / $15 preferred brand / $25 nonpreferred brand
Specialty drugs	10%
Pediatric dental[7,8] Diagnostic and preventive services	$0
Pediatric vision[7,9] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Policy for terms and conditions of coverage.

[1]In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles.

[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Gold 80 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$0
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$6,250 single / $12,500 family
Professional services Office visit copay	$30
Specialist visit	$50
Other practitioner office visit (including medically necessary acupuncture)	$30
Preventive care services[5]	$0
X-ray and diagnostic imaging	$50
Laboratory tests	$30
Imaging (CT/PET scans, MRIs)	20%
Rehabilitation and habilitation services	$30
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	20%
Hospital services Inpatient hospital stay (includes maternity)	20%
Skilled nursing care	20%
Emergency services Emergency room services (copayment waived if admitted)	$250
Urgent care	$60
Ambulance services (ground and air)	$250
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	20%
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$30
Home health care services (100 visits per calendar-year)	20%
Other services Durable medical equipment	20%
Hospice service	$0
Self-injectables (other than insulin)	20%
Prescription drug coverage Brand-name calendar-year deductible	N/A
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 generic / $50 preferred brand / $70 nonpreferred brand
Specialty drugs	20%
Pediatric dental[7,8] Diagnostic and preventive services	$0
Pediatric vision[7,9] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year

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[1]In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles.

[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Silver 70 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$2,000 single / $4,000 family
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$6,250 single / $12,500 family
Professional services Office visit copay	$45 (deductible waived)
Specialist visit	$65 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture)	$45 (deductible waived)
Preventive care services[5]	$0 (deductible waived)
X-ray and diagnostic imaging	$65 (deductible waived)
Laboratory tests	$45 (deductible waived)
Imaging (CT/PET scans, MRIs)	20% (deductible applies)
Rehabilitation and habilitation services	$45 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	20% (deductible waived)
Hospital services Inpatient hospital stay (includes maternity)	20% (deductible applies)
Skilled nursing care	20% (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	$250 (deductible applies)
Urgent care	$90 (deductible waived)
Ambulance services (ground and air)	$250 (deductible applies)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	20% (deductible waived)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$45 (deductible waived)
Home health care services (100 visits per calendar-year)	20% (deductible waived)
Other services Durable medical equipment	20% (deductible waived)
Hospice service	0% (deductible waived)
Self-injectables (other than insulin)	20% (deductible applies)
Prescription drug coverage Brand-name calendar-year deductible	$250 single / $500 family
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 generic (deductible waived) / $50 preferred brand / $70 nonpreferred brand
Specialty drugs	20% (deductible applies)
Pediatric dental[7,8] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[7,9] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

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[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Bronze 60 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$5,000 single / $10,000 family
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$6,250 single / $12,500 family
Professional services Office visit copay	Visits 1–3 $60 (deductible waived) / Visits 4+ $60 (deductible applies)
Specialist visit	$70 (deductible applies)
Other practitioner office visit (including medically necessary acupuncture)	$60 (deductible applies)
Preventive care services[5]	$0 (deductible waived)
X-ray and diagnostic imaging	30% (deductible applies)
Laboratory tests	30% (deductible applies)
Imaging (CT/PET scans, MRIs)	30% (deductible applies)
Rehabilitation and habilitation services	$60 (deductible applies)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	30% (deductible applies)
Hospital services Inpatient hospital stay (includes maternity)	30% (deductible applies)
Skilled nursing care	30% (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	$300 (deductible applies)
Urgent care	Visits 1–3 $120 (deductible waived) / Visits 4+ $120 (deductible applies)
Ambulance services (ground and air)	$300 (deductible applies)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	30% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	Visits 1–3 $60 (deductible waived) / Visits 4+ $60 (deductible applies)
Home health care services (100 visits per calendar-year)	30% (deductible applies)
Other services Durable medical equipment	30% (deductible applies)
Hospice service	$0 (deductible waived)
Self-injectables (other than insulin)	30% (deductible applies)
Prescription drug coverage Brand-name calendar-year deductible	Integrated with plan calendar-year deductible
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 generic (deductible waived) / $50 preferred brand / $75 nonpreferred brand
Specialty drugs	30% (deductible applies)
Pediatric dental[7,8] Diagnostic and preventive services	0% (deductible waived)
Pediatric vision[7,9] Routine eye exam	0% (deductible waived)
Glasses (limitations apply)	1 pair per year

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[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Minimum Coverage EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$6,600 single / $13,200 family
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$6,600 single / $13,200 family
Professional services Office visit copay	Visits 1–3 0% (deductible waived) / Visits 4+ 0% (deductible applies)
Specialist visit	0% (deductible applies)
Other practitioner office visit (including medically necessary acupuncture)	0% (deductible applies)
Preventive care services[5]	$0 (deductible waived)
X-ray and diagnostic imaging	0% (deductible applies)
Laboratory tests	0% (deductible applies)
Imaging (CT/PET scans, MRIs)	0% (deductible applies)
Rehabilitation and habilitation services	0% (deductible applies)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	0% (deductible applies)
Hospital services Inpatient hospital stay (includes maternity)	0% (deductible applies)
Skilled nursing care	0% (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	0% (deductible applies)
Urgent care	Visits 1–3 0% (deductible waived) / Visits 4+ 0% (deductible applies)
Ambulance services (ground and air)	0% (deductible applies)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	0% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	Visits 1–3 0% (deductible waived) / Visits 4+ 0% (deductible applies)
Home health care services (100 visits per calendar-year)	0% (deductible applies)
Other services Durable medical equipment	0% (deductible applies)
Hospice service	0% (deductible applies)
Self-injectables (other than insulin)	0% (deductible applies)
Prescription drug coverage Brand-name calendar-year deductible	Integrated with plan calendar-year deductible
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	0% (deductible applies)
Specialty drugs	0% (deductible applies)
Pediatric dental[7,8] Diagnostic and preventive services	0% (deductible waived)
Pediatric vision[7,9] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

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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.

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[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Silver 94 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$0
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$2,250 single / $4,500 family
Professional services Office visit copay	$3
Specialist visit	$5
Other practitioner office visit (including medically necessary acupuncture)	$3
Preventive care services[5]	$0
X-ray and diagnostic imaging	$5
Laboratory tests	$3
Imaging (CT/PET scans, MRIs)	10%
Rehabilitation and habilitation services	$3
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	10%
Hospital services Inpatient hospital stay (includes maternity)	10%
Skilled nursing care	10%
Emergency services Emergency room services (copayment waived if admitted)	$25
Urgent care	$6
Ambulance services (ground and air)	$25
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	10%
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$3
Home health care services (100 visits per calendar-year)	10%
Other services Durable medical equipment	10%
Hospice service	$0
Self-injectables (other than insulin)	10%
Prescription drug coverage Brand-name calendar-year deductible	N/A
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$3 generic / $5 preferred brand / $10 nonpreferred brand
Specialty drugs	10%
Pediatric dental[7,8] Diagnostic and preventive services	$0
Pediatric vision[7,9] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Silver 87 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$500 single / $1,000 family
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$2,250 single / $4,500 family
Professional services Office visit copay	$15 (deductible waived)
Specialist visit	$20 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture)	$15 (deductible waived)
Preventive care services[5]	$0 (deductible waived)
X-ray and diagnostic imaging	$20 (deductible waived)
Laboratory tests	$15 (deductible waived)
Imaging (CT/PET scans, MRIs)	15% (deductible applies)
Rehabilitation and habilitation services	$15 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	$15 (deductible waived)
Hospital services Inpatient hospital stay (includes maternity)	$15 (deductible applies)
Skilled nursing care	$15 (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	$75 (deductible applies)
Urgent care	$30 (deductible waived)
Ambulance services (ground and air)	$75 (deductible applies)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	15% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$15 (deductible waived)
Home health care services (100 visits per calendar-year)	15% (deductible waived)
Other services Durable medical equipment	15% (deductible waived)
Hospice service	0% (deductible waived)
Self-injectables (other than insulin)	15% (medical deductible applies)
Prescription drug coverage Brand-name calendar-year deductible	$50 single / $100 family
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$5 generic / $15 preferred brand (brand-name deductible applies) / $25 non-preferred brand (brand-name deductible applies)
Specialty drugs	15% (deductible applies)
Pediatric dental[7,8] Diagnostic and preventive services	$0
Pediatric vision[7,9] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Policy for terms and conditions of coverage.

[1]In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles.

[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Silver 73 EPO

Benefit description	Member(s) responsibility[1,2,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar-year deductible	$1,600 single / $3,200 family
Out-of-pocket maximum[4] (Includes calendar-year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar-year out-of-pocket maximum.)	$5,200 single / $10,400 family
Professional services Office visit copay	$40 (deductible waived)
Specialist visit	$50 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture)	$40 (deductible waived)
Preventive care services[5]	$0 (deductible waived)
X-ray and diagnostic imaging	$50 (deductible waived)
Laboratory tests	$40 (deductible waived)
Imaging (CT/PET scans, MRIs)	20% (deductible applies)
Rehabilitation and habilitation services	$40 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	20% (deductible waived)
Hospital services Inpatient hospital stay (includes maternity)	20% (deductible applies)
Skilled nursing care	20% (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	$250 (deductible applies)
Urgent care	$80 (deductible waived)
Ambulance services (ground and air)	$250 (deductible applies)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	20% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	$40 (deductible waived)
Home health care services (100 visits per calendar-year)	20% (deductible waived)
Other services Durable medical equipment	20% (deductible waived)
Hospice service	0% (deductible waived)
Self-injectables (other than insulin)	20% (medical deductible applies)
Prescription drug coverage Brand-name calendar-year deductible	$250 single / $500 family
Prescription drugs[6] (up to a 30-day supply obtained through a participating pharmacy)	$15 generic (deductible waived) / $35 preferred brand (brand-name deductible applies) / $60 non-preferred brand (brand-name deductible applies)
Specialty drugs	20% (deductible applies)
Pediatric dental[7,8] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[7,9] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Policy for terms and conditions of coverage.

[1]In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles.

[2]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the Policy for details.

[3]Please refer to the Policy for out-of-network reimbursement methodology.

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

[5]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); women's preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and comprehensive guidelines supported by HRSA for infants, children and adolescents. For more information on generally recommended preventive services, go to www.healthcare.gov. The applicable cost-sharing for preventive care will apply to these services.

[6]The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary. The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your Policy and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. The Policy is a legal, binding document. If the information in this brochure differs from the information in the Policy, the Policy controls. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

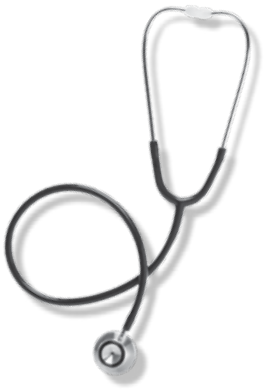
[7]Pediatric dental and vision are included on all plans.

[8]The pediatric dental benefits are underwritten by Health Net Life Insurance Company and administered by Dental Benefit Providers, Inc., dba Dental Benefit Administrative Services (DBP Entities). DBP Entities are not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Policy for details.

[9]The pediatric vision services benefits are underwritten by Health Net Life Insurance Company. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Major medical expense coverage

This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care, and prosthetic appliances subject to any deductibles, copayment provisions or other limitations which may be set forth in the Policy.



Principal benefits and coverages

Please refer to the list below for a summary of each plan's covered services and supplies. Also refer to the Policy you receive after you enroll in a plan. The Policy offers more detailed information about the benefits and coverage included in your health insurance plan. **Note:** EPO insurance plans do not cover health care services outside of the PureCare One network, except for emergency and urgent care.

- Allergy serum
- Allergy testing and treatment
- Ambulance services – ground ambulance transportation and air ambulance transportation
- Ambulatory surgical center
- Bariatric (weight loss) surgery
- Care for conditions of pregnancy
- Clinical trials
- Corrective footwear to prevent or treat diabetes-related complications
- Diabetic equipment
- Diagnostic imaging (including X-ray) and laboratory procedures
- Habilitation therapy
- Home health care agency services
- Hospice care
- Inpatient hospital services
- Medically necessary implanted lens that replaces the organic eye lens
- Medically necessary reconstructive surgery
- Medically necessary surgically implanted drugs
- Mental health care and chemical dependency benefits
- Outpatient hospital services
- Outpatient infusion therapy
- Organ, tissue and bone marrow transplants
- Patient education (including diabetes education)
- Pediatric vision as specified in the Policy
- Phenylketonuria (PKU)
- Pregnancy and maternity services
- Preventive care services
- Professional services
- Prostheses
- Radiation therapy, chemotherapy and renal dialysis treatment
- Rehabilitation therapy (including physical, speech, occupational, cardiac, and pulmonary therapy)
- Rental or purchase of durable medical equipment
- Self-injectable drugs
- Skilled nursing facility
- Sterilizations for males and females
- Treatment for dental injury, if medically necessary

Reproductive health services
Some hospitals and other providers do not provide one or more of the following services that may be covered under your Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net Life's Customer Contact Center at 1-888-926-4988 to ensure that you can obtain the health care services that you need.

Cost-sharing

Coverage is subject to deductible(s), coinsurances and copayments. Please consult the Policy for complete details.

Certification (prior authorization of services)

Some services are subject to precertification. Please consult the complete list of services in the Policy.

Exclusions and limitations

The following is a partial list of services that are not generally covered. For complete details about any plan's exclusions and limitations, please see the Policy for complete details.

- Services or supplies that are not medically necessary.
- Any amounts in excess of the maximum amounts specified in the Policy.
- Cosmetic surgery, except as specified in the Policy.
- Dental services, except as specified in the Policy.
- Treatment and services for temporomandibular (jaw) joint disorders (TMJ) (except medically necessary surgical procedures).
- Surgery and related services for the purposes of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are medically necessary.
- Food, dietary or nutritional supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Vision care for adults age 19 and older, including certain eye surgeries to replace glasses, except as specified in the Policy.
- Optometric services or eye exercises for adults age 19 and older, except as specifically stated elsewhere in the Policy.
- Eyeglasses or contact lenses for adults age 19 and older, except as specified in the Policy.
- Sex changes.
- Services to reverse voluntary surgically induced infertility.
- Services or supplies that are intended to impregnate a woman are not covered. The following services and supplies are excluded from fertility preservation coverage: gamete or embryo storage; use of frozen gametes or embryos to achieve future conception; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; gestational carriers (surrogates).
- Certain genetic testing.
- Experimental or investigative services.

- Routine physical exams, except for preventive care services (e.g., physical exam for insurance, licensing, employment, school, or camp). Any physical, vision or hearing exams, which are not related to a diagnosis or treatment of illness or injury, except as specifically stated in the Policy.
- Immunizations or inoculations for adults or children for foreign travel or occupational purposes.
- Services not related to a covered illness or injury. However, treatment of complications arising from non-covered services, such as complications due to non-covered cosmetic surgery, are covered.
- Custodial or domiciliary care.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility, primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
- Any services or supplies furnished by a non-eligible institution, which is other than a legally operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how it is designated.
- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate.
- Infertility services.
- Private duty nursing.
- Over-the-counter medical supplies and medications, except as specified in the Policy.
- Personal comfort items.
- Orthotics, unless custom made to fit the covered person's body and as specified in the Policy.
- Educational services or nutritional counseling, except as specified in the Policy.
- Hearing aids.
- Obesity-related services except as stated in the Policy.
- Any services received by Medicare benefits without payment of additional premium.
- Services received before your effective date of coverage.
- Services received after coverage ends.
- Services for which no charge is made to the covered person in the absence of insurance coverage, except services received at a charitable research hospital, which is not operated by a governmental agency.
- Physician self-treatment.
- Services performed by a person who lives in the covered person's home or who is related to the covered person by blood or marriage.
- Conditions caused by the covered person's commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.
- Conditions caused by release of nuclear energy, when government funds are available.
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.

- Services for a surrogate pregnancy are covered when the surrogate is a Health Net insured. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as stated in the Policy.
- Services and supplies obtained while in a foreign country with the exception of emergency care.
- Home birth, unless criteria for emergency care have been met.
- Reimbursement for services for which the covered person is not legally obligated to pay the provider in the absence of insurance coverage.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the covered person's residence to accommodate the covered person's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Disposable supplies for home use, except for diabetic supplies as listed in the Policy.

Some services require precertification from Health Net prior to receiving services. Please refer to your Policy for details on what services and procedures require precertification.

Health Net Life does not require precertification for dialysis services or maternity care. However, please call the Customer Contact Center at 1-888-926-4988 upon initiation of dialysis services or at the time of the first prenatal visit.

Precertification is also not required for behavioral health treatment for autism. However, please provide Health Net Life with documentation that a licensed physician or licensed psychologist has established the diagnosis of autism. In addition, the qualified autism service provider must submit the initial treatment plan to Health Net Life. Please refer to your Policy for details.

Renewability of this Policy

Subject to the termination provisions discussed in the Policy, coverage will remain in effect for each month premiums are received and accepted by Health Net Life.

Premiums

We may adjust or change your premium. If we change your premium amount, notice will be mailed to you at least 60 days prior to the premium change effective date. Premiums are automatically adjusted for changes in your and your dependent spouse's or registered domestic partner's ages. Premiums may be adjusted when your residence address changes.

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 us at the number listed on your ID card or please call:
Individual & Family Plans: 1-888-926-4988
Small Business: 1-888-926-5133
TDD/TYY: 1-888-926-5180

For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al:
Planes Individuales y Familiares: 1-888-926-4988
Pequeñas Empresas: 1-888-926-5133
TDD/TYY: 1-888-926-5180

Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。
如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或請撥：
Individual & Family Plans：1-888-926-4988
小型企業：1-888-926-5133
聽 / 語障專線：1-888-926-5180

如需其他協助：如果您投保的是由 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是由 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi:
Chương trình bảo hiểm dành cho cá nhân và gia đình: 1-888-926-4988
Chương trình bảo hiểm dành cho tiểu thương nghiệp: 1-888-926-5133
Số TDD/TYY: 1-888-926-5180

Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다.
도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 다음 안내번호로 문의하십시오.
개인 및 가족 플랜: 1-888-926-4988
스몰 비즈니스: 1-888-926-5133
TDD/TTY: 1-888-926-5180

더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o mangyaring tumawag sa:
Individual & Family Plans: 1-888-926-4988
Small Business: 1-888-926-5133
TDD/TYY: 1-888-926-5180

Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ խնդրում ենք զանգահարել՝
Անհատական և Ընտանեկան Ծրագրեր՝ 1-888-926-4988
Փոքր Ձեռնարկություններ՝ 1-888-926-5133
Խուլերի համար սարք (TDD/TTY)՝ 1-888-926-5180

Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте.
Планы индивидуального и семейного страхования: 1-888-926-4988
Малый бизнес: 1-888-926-5133
Линия TDD/TTY: 1-888-926-5180

Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または以下の番号までご連絡ください。
個人および家族プラン：1-888-926-4988
中小企業：1-888-926-5133
TDD/TTY専用番号：1-888-926-5180

さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس گرفته و یا به شماره های زیر تلفن کنید:
طرح افراد و خانواده ها: 1-888-926-4988
کسب و کار کوچک: 1-888-926-5133
TDD/TTY: 1-888-926-5180

برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company یا Health Net of California, Inc. صادر شده است.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇਥੇ ਫੋਨ ਕਰੋ:
ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾਵਾਂ: 1-888-926-4988
ਛੋਟਾ ਕਾਰੋਬਾਰ: 1-888-926-5133
TDD/TYY: 1-888-926-5180

ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមក យើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទទៅ :
គំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ : 1-888-926-4988
ពាណិជ្ជកម្មតូច : 1-888-926-5133
លេខ TDD/TTY : 1-888-926-5180

សំរាប់ជំនួយបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងច្បាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357. បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc. ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis thov hu rau:
Kev Npaj Pab Tus Kheej thiab Tsev Neeg (Individual and Family Plan; IFP): 1-888-926-4988
Cov Lagluam Me: 1-888-926-5133
Tus Xovtooj TDD/TTY: 1-888-926-5180

Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago t'áá shǫǫdí kohjį' hodíilnih:
Ła' Jizíh dóó Hooghan Haz'ą́ągi Naaltsoos Hadadít'éhígíí (IFP): 1-888-926-4988
T'áá 'ałtszíísígo Naalyéhí Báhooghan Daayéełyeedígíí: 1-888-926-5133
TDD/TYY: 1-888-926-5180

T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ą́ąh naa'nil bibee haz'áanii Health Net Life Insurance Company bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'áchą́ąh naa'nil bił haz'ánígíí bich'į' kohjį' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dęę' bikáá'.

Navajo

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على مساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو الاتصال بـ:
خطط الفرد والأسرة: 1-888-926-4988
Small Business (الأعمال الصغيرة): 1-888-926-5133
رقم الهاتف النصي/خط ضعاف السمع: 1-888-926-5180

للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

Health Net Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150

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

Assistance for the Hearing and Speech Impaired
1-800-995-0852

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