

# California Individual & Family Plans

## Available Through Covered California™



### Silver 94 Ambetter PPO

The Silver 94 Ambetter PPO health Plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network.

**Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE ("PLAN CONTRACT AND EOC") AND SCHEDULE OF BENEFITS SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments (also called Coinsurance) are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

| Benefit description                                                                  | Member(s) responsibility                                      |                                                                           |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------|
|                                                                                      | In-network <sup>1,2</sup>                                     | Out-of-network <sup>1,3</sup>                                             |
| Unlimited lifetime maximum.<br>Benefits are subject to a Deductible unless noted.    |                                                               |                                                                           |
| <b>Plan maximums</b>                                                                 |                                                               |                                                                           |
| Calendar year deductible <sup>4</sup>                                                | \$200 single / \$400 family                                   | \$5,000 single / \$10,000 family                                          |
| Out-of-Pocket Maximum (includes Calendar Year Deductible) <sup>5</sup>               | \$3,000 single / \$6,000 family                               | \$25,000 single / \$50,000 family                                         |
| <b>Professional services</b>                                                         |                                                               |                                                                           |
| Office visit                                                                         | \$5                                                           | 50% after Deductible                                                      |
| Telehealth consultation through the Select Telehealth Services Provider <sup>6</sup> | \$0                                                           | Not covered                                                               |
| Specialist consultation                                                              | \$8                                                           | 50% after Deductible                                                      |
| Medically necessary acupuncture                                                      | \$5                                                           | Not covered                                                               |
| Preventive Care Services <sup>7</sup>                                                | \$0                                                           | Not covered                                                               |
| X-ray and diagnostic imaging                                                         | \$10                                                          | 50% after Deductible                                                      |
| Laboratory procedures                                                                | \$10                                                          | 50% after Deductible                                                      |
| Imaging (CT/PET scans, MRIs)                                                         | \$50                                                          | 50% after Deductible                                                      |
| Rehabilitation and habilitation therapy                                              | \$5                                                           | Not covered                                                               |
| <b>Outpatient services</b>                                                           |                                                               |                                                                           |
| Outpatient surgery                                                                   | 10%                                                           | 50% after Deductible                                                      |
| <b>Hospital services</b>                                                             |                                                               |                                                                           |
| Inpatient hospital facility services (includes maternity)                            | Facility: 10% after Deductible <sup>8</sup><br>Physician: 10% | 50% after Deductible                                                      |
| Skilled nursing facility (maximum of 100 days per calendar year for each member)     | 10% after Deductible                                          | 50% after Deductible                                                      |
| <b>Emergency services and care</b>                                                   |                                                               |                                                                           |
| Emergency room (Copayment waived if admitted)                                        | Facility: \$50; Physician: \$0                                | Facility: \$50 (Deductible waived);<br>Physician: \$0 (Deductible waived) |
| Urgent care                                                                          | \$5                                                           | 50% after Deductible                                                      |
| Ambulance services (ground and air)                                                  | \$30                                                          | Payable at the Preferred Provider level of benefits (Deductible waived)   |
| <b>Mental/Behavioral health/Substance use disorder services<sup>8</sup></b>          |                                                               |                                                                           |
| Mental/Behavioral health/Substance use disorder (inpatient)                          | 10% after Deductible                                          | 50% after Deductible                                                      |
| Mental/Behavioral health/Substance use disorder (outpatient)                         | Office visit: \$5<br>Other than office visit: \$0             | 50% after Deductible                                                      |
| <b>Home health care services</b> (100 visits/year)                                   | \$3                                                           | Not covered                                                               |
| <b>Other services</b>                                                                |                                                               |                                                                           |
| Durable medical equipment                                                            | 10%                                                           | Not covered                                                               |
| Hospice service                                                                      | \$0                                                           | 50% after Deductible                                                      |

| Benefit description                                                                                                                                               | Member(s) responsibility   |                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------|
|                                                                                                                                                                   | In-network <sup>1,2</sup>  | Out-of-network <sup>1,3</sup> |
| <b>Prescription drug coverage</b> <sup>9</sup><br>(up to a 30-day supply obtained through a participating pharmacy)<br>Prescription Drug Calendar Year Deductible | \$0                        | Not covered                   |
| Tier 1 (most generics and low-cost preferred brands)                                                                                                              | \$3                        | Not covered                   |
| Tier 2 (non-preferred generics and preferred brands)                                                                                                              | \$10                       | Not covered                   |
| Tier 3 (non-preferred brands)                                                                                                                                     | \$15                       | Not covered                   |
| Tier 4 (Specialty drugs)                                                                                                                                          | 10% up to \$150 per script | Not covered                   |
| <b>Pediatric dental</b> <sup>10, 11</sup><br>Diagnostic and preventive services                                                                                   | \$0                        | Not covered                   |
| <b>Pediatric vision</b> <sup>10, 12</sup><br>Eye exam                                                                                                             | \$0                        | Not covered                   |
| Glasses                                                                                                                                                           | 1 pair per year – \$0      | Not covered                   |

**THIS IS A SUMMARY OF BENEFITS. IT DOES NOT INCLUDE ALL SERVICES, LIMITATIONS OR EXCLUSIONS. PLEASE REFER TO THE *PLAN CONTRACT AND EOC* FOR TERMS AND CONDITIONS OF COVERAGE.**

<sup>1</sup> Certain services require prior authorization from Health Net. Without prior authorization, an additional \$250 is applied for in-network providers, and \$500 is applied for out-of-network providers. Refer to the *Plan Contract and EOC* for details.

<sup>2</sup> Member pays coinsurance based on the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

<sup>3</sup> Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

<sup>4</sup> Any amount applied toward the calendar year deductible for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers.

<sup>5</sup> 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. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

<sup>6</sup> You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your primary care provider.

<sup>7</sup> Preventive Care Services are covered for children and adults, as directed by your Physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) Grade A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive Care Services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

<sup>8</sup> If a Hospital does not bill charges for inpatient professional services separately from the inpatient facility fee, the Deductible will apply.

<sup>9</sup> The Ambetter from Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and participating pharmacies. Some drugs on the List may require Prior Authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. For a copy of the Ambetter from Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at [www.myhealthnetca.com](http://www.myhealthnetca.com).

<sup>10</sup> Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

<sup>11</sup> The pediatric dental benefits are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

<sup>12</sup> The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC, to administer the pediatric vision services benefits.

Ambetter from Health Net PPO plans are offered by Health Net of California, Inc. Health Net of California, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. Covered California is a registered trademark of the State of California. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

## 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, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

## Arabic

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 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。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打 1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（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, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोजित सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (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 cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (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。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・家族向けプラン（IFP）の申込者の方は、1-877-609-8711（TTY: 711）までお電話ください。

## Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យ  
លោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានប័ណ្ណសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់  
លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅ  
កាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំ  
គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (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 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에  
1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우  
1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

## Navajo

Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóót'íjł. Naaltsoos da t'áá  
shí shizaad k'éhjí shichí' yídooltah nínízingo t'áá ná ákódoolníł. Ákót'éego shíká a'doowoł nínízingo  
Customer Contact Center hoolyéhíjł' hodíílnih ninaaltsoos nanítingo bee néého'dolzinígíí hodoonihjł'  
bikáá'. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojí' hodíílnih Health Net's Commercial  
Contact Center 1-800-522-0088 (TTY: 711). T'áá hó dóó ha'áłchíní (IFP) báhígíí éí kojí' hojilnih  
1-877-609-8711 (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، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس  
تجاری Health Net به شماره 1-800-522-0088 (TTY: 711) تماس بگیرید. متقاضیان طرح فردی و خانوادگی (IFP) \* لطفاً با  
شماره 1-877-609-8711 (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, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ  
ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ  
1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ  
1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

## Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочесть  
документы на Вашем родном языке. Если Вам нужна помощь и у Вас при себе есть карточка  
участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов,  
предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону  
1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звоните по телефону  
1-877-609-8711 (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, si tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (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, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

## **Thai**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (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 cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nếu quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).

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