



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.healthnet.com/2020/eoc/pco/epo/bronze60iex](http://www.healthnet.com/2020/eoc/pco/epo/bronze60iex) or call 1-888-926-4988. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or [www.myhealthnetca.com](http://www.myhealthnetca.com) or you can call 1-888-926-4988 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | For preferred providers \$6,300 per person / \$12,600 per family per calendar year.                                                                                                                                                                                                                                                                                                                                     | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive care, first 3 non-preventive visits per year combined (including non-preventive primary care, specialist & other practitioner office visits, urgent care visits), x-ray & lab, mental health & substance use disorder office visits, prenatal office visits, rehabilitation & habilitation, hospice, and pediatric dental and vision care are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. Preferred pharmacy deductible \$500 per person / \$1,000 per family per calendar year. Pharmacy deductible applies to tiers 1-4. There are no other specific <a href="#">deductibles</a> .                                                                                                                                                                                                                         | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For preferred providers \$7,800 per person / \$15,600 per family per calendar year.                                                                                                                                                                                                                                                                                                                                     | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for non-certification and healthcare this <a href="#">plan</a> doesn't cover.                                                                                                                                                                                                                                                             | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. For a list of <b>preferred providers</b> , see <a href="http://www.myhealthnetca.com/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988.                                                                                                                                                                                                                                                    | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                                                                                                                                                     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                                 | Services You May Need                            | What You Will Pay                                                                                  |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                      |
|----------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                      |                                                  | Preferred Provider<br>(You will pay the least)                                                     | Out of Network Provider<br>(You will pay the most) |                                                                                                                                                                             |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$65/visit<br>deductible waived for 1 <sup>st</sup> 3 visits                                       | Not covered                                        | Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, specialist, other practitioner office visits & urgent care visits). |
|                                                                      | <u>Specialist</u> visit                          | \$95/visit<br>deductible waived for 1 <sup>st</sup> 3 visits                                       | Not covered                                        | Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, specialist, other practitioner office visits & urgent care visits). |
|                                                                      | <u>Preventive care/screening/immunization</u>    | No charge                                                                                          | Not covered                                        | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.                   |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)       | Lab-\$40/visit<br>deductible does not apply<br>X-ray-40% coinsurance after deductible has been met | Not covered                                        | _____none_____                                                                                                                                                              |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | 40% coinsurance after deductible has been met                                                      | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                |

| Common Medical Event                                                                                                                                                                                                                                                    | Services You May Need                                    | What You Will Pay                                                                                           |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                         |                                                          | Preferred Provider<br>(You will pay the least)                                                              | Out of Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.myhealthnetca.com/druglist">prescription drug coverage</a> is available at <a href="http://www.myhealthnetca.com/druglist">www.myhealthnetca.com/druglist</a> | Preferred generic drugs (tier 1)                         | \$18/retail order<br>\$36/mail order<br>after preferred pharmacy deductible has been met                    | Not covered                                        | Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care. Preferred pharmacy deductible applies \$500 per member / \$1,000 per family. Tier 2 and Tier 3 drugs will have a coinsurance maximum of \$500 per individual prescription for up to a 30-day supply or \$1,500 for a 90-day supply. |
|                                                                                                                                                                                                                                                                         | Non-preferred generic and preferred brand drugs (tier 2) | 40% coinsurance up to a maximum of \$500 per 30 day script after preferred pharmacy deductible has been met | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                         | Non-preferred brand drugs (tier 3)                       | 40% coinsurance up to a maximum of \$500 per 30 day script after preferred pharmacy deductible has been met | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                         | Specialty drugs (tier 4)                                 | 40% coinsurance up to a maximum of \$500 per 30 day script after preferred pharmacy deductible has been met | Not covered                                        | Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Prior authorization is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care. Preferred pharmacy deductible applies \$500 per member / \$1,000 per family. Tier 4 drugs will have a coinsurance maximum of \$500 per individual prescription for up to a 30-day supply.                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)           | 40% coinsurance after deductible has been met                                                               | Not covered                                        | Some outpatient surgical procedures require certification or a \$250 penalty will apply.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                         | Physician/surgeon fees                                   | 40% coinsurance after deductible has been met                                                               | Not covered                                        | Some outpatient surgical procedures require certification.                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                                                                                                                            |                                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                    |
|----------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | Preferred Provider<br>(You will pay the least)                                                                                               | Out of Network Provider<br>(You will pay the most)                                                    |                                                                                                                                                                                                                           |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | Facility fee-<br>40% coinsurance after deductible has been met<br>Professional services-<br>No charge                                        | Facility fee-<br>40% coinsurance after deductible has been met<br>Professional services-<br>No charge | Cost sharing waived if admitted into the hospital.                                                                                                                                                                        |
|                                                                                  | <a href="#">Emergency medical transportation</a> | 40% coinsurance after deductible has been met                                                                                                | 40% coinsurance after deductible has been met                                                         | _____none_____                                                                                                                                                                                                            |
|                                                                                  | <a href="#">Urgent care</a>                      | \$65/visit<br>deductible waived for 1 <sup>st</sup> 3 visits                                                                                 | \$65/visit<br>deductible waived for 1 <sup>st</sup> 3 visits                                          | Deductible applies after first 3 non-preventive visits combined (including non-preventive primary care, specialist, other practitioner office visits & urgent care visits).                                               |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | 40% coinsurance after deductible has been met                                                                                                | Not covered                                                                                           | If certification is not obtained in a non-emergency a \$250 penalty will apply.                                                                                                                                           |
|                                                                                  | Physician/surgeon fees                           | 40% coinsurance after deductible has been met                                                                                                | Not covered                                                                                           | Certification is required for a hospital stay and some services received while admitted to the hospital.                                                                                                                  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | Office visit-\$65/visit<br>deductible does not apply<br>Other than office visit-<br>40% coinsurance up to \$65 after deductible has been met | Not covered                                                                                           | Certification is not required for outpatient services for mental health and substance use disorder diagnoses except for reconstructive surgery. If certification is required but not obtained a \$250 penalty will apply. |
|                                                                                  | Inpatient services                               | 40% coinsurance after deductible has been met                                                                                                | Not covered                                                                                           | If certification is not obtained in a non-emergency a \$250 penalty will apply.                                                                                                                                           |
| <b>If you are pregnant</b>                                                       | Office visits                                    | No charge                                                                                                                                    | Not covered                                                                                           | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.                                                                 |
|                                                                                  | Childbirth/delivery professional services        | 40% coinsurance after deductible has been met                                                                                                | Not covered                                                                                           | Coverage includes abortion services.                                                                                                                                                                                      |
|                                                                                  | Childbirth/delivery facility services            | 40% coinsurance after deductible has been met                                                                                                | Not covered                                                                                           | Coverage includes abortion services.                                                                                                                                                                                      |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                 |
|-----------------------------------------------------------------------|-------------------------------------------|------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Preferred Provider<br>(You will pay the least) | Out of Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 40% coinsurance after deductible has been met  | Not covered                                        | Limited to 100 visits per calendar year (rehabilitative and habilitative home health services are each limited to separate 100 visit limits per calendar year). Certification is required for some home health services or a \$250 penalty will apply. |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$65/visit deductible does not apply           | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                                                                                           |
|                                                                       | <a href="#">Habilitation services</a>     | \$65/visit deductible does not apply           | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                                                                                           |
|                                                                       | <a href="#">Skilled nursing care</a>      | 40% coinsurance after deductible has been      | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                                                                                           |
|                                                                       | <a href="#">Durable medical equipment</a> | 40% coinsurance after deductible has been met  | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                                                                                           |
|                                                                       | <a href="#">Hospice services</a>          | No charge                                      | Not covered                                        | If certification is not obtained a \$250 penalty will apply.                                                                                                                                                                                           |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                      | Not covered                                        | Limited to 1 visit per year.                                                                                                                                                                                                                           |
|                                                                       | Children's glasses                        | No charge                                      | Not covered                                        | Provider selected frames; 1 per calendar year.                                                                                                                                                                                                         |
|                                                                       | Children's dental check-up                | No charge                                      | Not covered                                        | Limited to 1 check-up every 6 months.                                                                                                                                                                                                                  |

#### Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover** (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- |                                                                                                                                  |                                                                                                                                                                                          |                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility services</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs (exclusion does not apply to preventive care behavioral interventions)</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                                                                                 |                                                                                                                                               |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion services</li> <li>• Acupuncture (covered when medically necessary)</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery (covered through the preferred provider network if medically necessary)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>.
- California Department of Insurance – 300 Capitol Mall Suite 1600 Sacramento CA 95814. Call toll free: (800) 927-4357 or visit <http://insurance.ca.gov/consumers>.
- Office of Personnel Management Multi State Plan Program: <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>.

For more information on your rights to continue coverage, contact the plan at 1-888-926-4988. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-888-926-4988, submit a grievance form through [www.myhealthnetca.com](http://www.myhealthnetca.com), or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If you have a grievance against Health Net, you can also contact the California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or at 1-800-927-HELP (4357), 1-800 482-4833 TDD or at [www.insurance.ca.gov](http://www.insurance.ca.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at the contact information provided above.

### **Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-926-4988.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-4988.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-4988.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-926-4988.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————



## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in network pre natal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,300 |
| ■ <a href="#">Specialist copayment</a>                          | \$95    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">copayment</a>                               | \$65    |

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$6,300        |
| Copayments                        | \$700          |
| Coinsurance                       | \$500          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,560</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in network care of a well controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,300 |
| ■ <a href="#">Specialist copayment</a>                          | \$95    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">copayment</a>                               | \$65    |

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,200        |
| Copayments                        | \$1,500        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,760</b> |

### Mia's Simple Fracture

(in network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,300 |
| ■ <a href="#">Specialist copayment</a>                          | \$95    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">copayment</a>                               | \$65    |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,500</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,400        |
| Copayments                        | \$600          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,000</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## *Nondiscrimination Notice*

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

### **Health Net:**

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

If you need these services, contact Health Net's Customer Contact Center at:

**Individual & Family Plan (IFP) Members On Exchange/Covered California** 1-888-926-4988 (TTY: 711)

**Individual & Family Plan (IFP) Members Off Exchange** 1-800-839-2172 (TTY: 711)

**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)

**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

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

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

Fax: 1-877-831-6019

Email: [Member.Discrimination.Complaints@healthnet.com](mailto:Member.Discrimination.Complaints@healthnet.com) (Members) or  
[Non-Member.Discrimination.Complaints@healthnet.com](mailto:Non-Member.Discrimination.Complaints@healthnet.com) (Applicants)

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

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

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

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



## English

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

## Arabic

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

## Armenian

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

## Chinese

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

## Hindi

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

## Hmong

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

## Japanese

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

## Khmer

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

## Korean

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

## Navajo

Doo báqah ilínigóó saad bee háká ada'ílyeed. Ata' halné'ígíí da ía' ná hádííóót'íí. Naaltsos da t'áá shí shízaad k'éhjí shichí' yídooltah nínízingo t'áá ná ákódoolnii. Ákót'éego shiká a'doowot nínízingo Customer Contact Center hooyéhi' hodiilnih ninaaltsos nantingo bee néého'dolzinigii hodoonihj' bikáá' éi doodago koj' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhiigii koj' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éi doodago Small Business báhiigii koj' hólne' -888-926-5133 (TTY: 711). Group Plans through Health Net báhiigii éi koj' hólne' 1-800-522-0088 (TTY: 711).

## Persian (Farsi)

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

### **Panjabi (Punjabi)**

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐਂਡ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐਂਡ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੈਲ ਬਿਜਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੇਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੇਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

### **Russian**

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

### **Spanish**

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

### **Tagalog**

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

### **Thai**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรมา TTY: 711) สำหรับเซตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมา TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมา TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมา 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, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance

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