



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 or call 1-800-522-0088. 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 www.dol.gov/ebsa/healthreform or www.healthnet.com or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	There is no deductible .	There is no deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,500 per member / \$5,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. For a list of preferred providers , see www.healthnet.com/providersearch or call 1-800-522-0088.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes. Requires written preauthorization .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .



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 In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay /visit	Not covered	None
	Specialist visit	\$50 copay /visit	Not covered	Requires preauthorization .
	Preventive care/screening/immunization	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.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 copay /visit	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	\$250 copay /procedure	Not covered	Requires preauthorization .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthnet.com	Generic drugs (Tier 1)	\$5 copay /retail order \$10 copay /mail order all generics except specialty generics	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Preauthorization is required for select drugs.
	Preferred brand drugs (Tier 2)	\$30 copay /retail order \$75 copay /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$50 copay /retail order \$125 copay /mail order Non-preferred brands only	Not covered	
	Specialty drugs (Tier 4)	Self injectables- 30% coinsurance Refer to the recommended drug list for other drugs considered specialty	Not covered	Supply/order: up to a 30 day supply filled by specialty pharmacy. Preauthorization is required for select drugs. Quantity limits may apply for select drugs. Tier 4: \$250 maximum out-of-pocket cost per 30 day script.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.healthnet.com.

Common Medical Event	Services You May Need	What You Will Pay In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital- \$500 copay /admission ASC- \$200 copay /admission	Not covered	Requires preauthorization .
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$250 copay /visit	\$250 copay /visit	Copay waived if admitted into the hospital.
	Emergency medical transportation	\$250 copay /transport	\$250 copay /transport	None
	Urgent care	Medical-\$50 copay /visit Mental health and substance use disorders-\$30 copay /visit	Medical-\$50 copay /visit Mental health and substance use disorders-\$30 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 copay /day	Not covered	4 day max copay per admission. Requires preauthorization .
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$30 copay /visit- individual therapy session \$15 copay /visit- group therapy session Other than office-No charge	Not covered	None
	Inpatient services	\$600 copay /day	Not covered	4 day max copay per admission. Requires preauthorization .
If you are pregnant	Office visits	Prenatal-\$30 copay /visit Postnatal-\$30 copay /visit	Not covered	Prenatal and postnatal preventive services are covered under preventive care.
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	\$600 copay /day	Not covered	4 day max copay per admission. Coverage includes abortion services.

Common Medical Event	Services You May Need	What You Will Pay In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	\$30 copay /visit	Not covered	Limited to 100 intermittent visits each calendar year. Requires preauthorization .
	Rehabilitation services	\$30 copay /visit	Not covered	Requires preauthorization .
	Habilitation services	\$30 copay /visit	Not covered	Requires preauthorization .
	Skilled nursing center	\$25 copay /day	Not covered	Requires preauthorization .
	Durable medical equipment	30% coinsurance	Not covered	Corrective footwear is not covered. Requires preauthorization .
	Hospice services	No charge	Not covered	Requires preauthorization .
If your child needs dental or eye care	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	None

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](#).)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (covered when medically necessary)
- Bariatric surgery
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

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 www.dol.gov/ebsa/healthreform. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 1-800-522-0088, submit a grievance form through www.healthnet.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. If you have a grievance against Health Net, you can also contact the California Department of Managed Health Care at 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhc.ca.gov. 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.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 1-800-522-0088.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-0088.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-522-0088.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-522-0088.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)																																											
▪ The plan's overall deductible	\$0	▪ The plan's overall deductible	\$0	▪ The plan's overall deductible	\$0																																										
▪ Specialist copayment	\$50	▪ Specialist copayment	\$50	▪ Specialist copayment	\$50																																										
▪ Hospital (facility) copayment	\$600	▪ Hospital (facility) copayment	\$600	▪ Hospital (facility) copayment	\$600																																										
▪ Other copayment	\$30	▪ Other copayment	\$30	▪ Other copayment	\$30																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																											
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800																																										
<p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$1,400</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$60</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$1,460</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$0	Copayments	\$1,400	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$60	The total Peg would pay is	\$1,460	<p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$1,000</td> </tr> <tr> <td>Coinsurance</td> <td>\$200</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$20</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$1,220</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$0	Copayments	\$1,000	Coinsurance	\$200	What isn't covered		Limits or exclusions	\$20	The total Joe would pay is	\$1,220	<p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$0</td> </tr> <tr> <td>Copayments</td> <td>\$1,100</td> </tr> <tr> <td>Coinsurance</td> <td>\$70</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$0</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$1,170</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$0	Copayments	\$1,100	Coinsurance	\$70	What isn't covered		Limits or exclusions	\$0	The total Mia would pay is	\$1,170
Cost Sharing																																															
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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), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

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

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

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

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

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

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

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

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

Fax: 1-877-831-6019

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

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

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

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

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

English

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

Arabic

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

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Համայնքային սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Վարիֆորնիայի 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 Իմֆային 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

សេវាកម្មភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសាស្រីលោកអ្នក។ 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 bąąh ilinígóó saad bee háká ada'ílyeed. Ata' halné'ígíí da la' ná hádííóót'íí. Naaltsos da t'áá shí shizaad k'ehjí shichí' yidooltah nínizingo t'áá ná ákódoolnít. Ákót'éego shiká a'doowot nínizingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsos nantingo bee néého'dolznígíí hodoonhíjí' bikáá' éi doodago kojí' hólné' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojí' hólné' IFP On Exchange 1-888- 926-4988 (TTY: 711) éi doodago Small Business báhígíí kojí' hólné' -888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éi kojí' hólné' 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 ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) 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 ਬਿਜਨੈਸ 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 представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish

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

Tagalog

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

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (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

FLY017549EH00 (12/17)

Platinum HMO

Groups Beginning 7/1/22

Services	HMO C
Participating Health Plans	Health Net
Network Name	WholeCare
Metal Tier	Platinum
Calendar Year Deductible*	None
Out-of-Pocket Max Ind/Fam	\$2,500 / \$5,000
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	\$30 Copay
Specialist Visit (SPC)	\$50 Copay
Laboratory	\$30 Copay
X-Ray	\$30 Copay
MRI, CT and PET (office setting)	\$250 Copay per procedure
Virtual/Telemedicine Office Visit	100%
Hospital Services – In-Patient	\$600 Copay per day – 4 days max
In-Patient Physician Fees	100%
Emergency Room (copay waived if admitted)	\$250 Copay
Urgent Care	\$50 Copay
Hospital Services – Out-Patient	
Surgical Facility Ambulatory Surgery Center	\$500 Copay \$200 Copay ²
Hospital Pre-Authorization	Required
2nd Surgical Opinion	\$50 Copay
Ambulance Services (per trip)	\$250 Copay
Rx Benefits	
Generic	\$5 Copay ^{6,7}
Formulary Brand	\$30 Copay ^{6,7}
Non-Formulary Brand	\$50 Copay ^{6,7}
Specialty	70% (up to \$250 per prescription ¹⁴) (prior auth. required) ^{6,7}
Oral Contraceptives	100%
Diabetes – Self-Injectable	Applicable Rx Copay ^{6,7}
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any illness
Preventive/Wellness Services	100% ⁴
Chronic Disease Management	\$50 Copay
Chemotherapy	100%
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	\$10 Copay ¹
Physical, Occupational, Speech Therapy	\$30 Copay ¹⁸
Rehabilitative & Habilitative Services and Devices	\$30 Copay ¹⁸
Home Health Care (Max 100 visits per year)	\$30 Copay

Platinum HMO

Groups Beginning 7/1/22

Services		HMO C
Participating Health Plans		Health Net
Network Name		WholeCare
Metal Tier		Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)		\$25 Copay per day (no limit)
Hospice (out-patient)		100%
Durable Medical Equipment (Covered when medically necessary)		70%
Mental Health		
In-Patient		\$600 Copay per day – 4 days max ⁵
Out-Patient (office visit)		\$30 Copay ⁵
Drug/Substance Abuse		
In-Patient (Detox Only)		\$600 Copay per day – 4 days max
Infertility		
Infertility Evaluation and Treatment		Not Covered
Infertility Drugs		Not Covered
In Vitro Fertilization (IVF)		Not Covered
Gamete Intrafallopian Transfer (GIFT)		Not Covered
Zygote Intrafallopian Transfer (ZIFT)		Not Covered
Pediatric Vision		
Carrier		EyeMed ¹⁰
Network		EyeMed
Exam		100%
Contact Lenses		100%
Frames		1 pair per calendar year
Maximum Allowance per year		None
Pediatric Dental		
Carrier		Dental Benefit Providers ^{8, 10}
Network		Dental Benefit Providers
Deductible		None
Out-of-Pocket Maximum		Combined with Medical
Office Visit		100%
Diagnostic & Preventative (D&P)		100%
Basic Services		Copay varies by service
Major Services (no waiting period)		Copay varies by service
Orthodontics (medically necessary)		Copay varies by service

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* All services are subject to the deductible unless otherwise stated.

1. Must be medically necessary.

2. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.

3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.

4. See plan specific EOC for information on preventive services.

5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.

7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.

9. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

10. Pediatric dental and vision are included on all plans.

11. Limited to 100 4-hour visits per benefit period.

12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.

13. Evaluation only.

14. Maximum member responsibility.

15. Medical emergency only.

16. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.

17. Manipulation Therapy only; benefit maximum of 20 visits per benefit period, office and outpatient visits combined.

18. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

19. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).

20. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

21. Dr. Visits (PCP)/ Specialist Visit (SPC). \$0 Copay for virtual visits through online provider – LiveHealth Online.

22. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.