



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](http://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 <https://www.healthcare.gov/sbc-glossary/> or [www.healthnet.com](http://www.healthnet.com) or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall deductible?</b>	For <a href="#">preferred providers</a> : \$1,700 member/\$3,400 family per calendar year. For <a href="#">out-of-network providers</a> : \$3,400 member/\$6,800 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on Page 2.	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> .
<b>Are there other deductibles for specific services?</b>	Yes. Pharmacy <a href="#">deductible</a> : \$300 member/\$600 family per calendar year (applies to Tiers 2-4). 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.
<b>What is the out-of-pocket limit for this plan?</b>	For <a href="#">preferred providers</a> : \$9,200 member/\$18,400 family per calendar year. For <a href="#">out-of-network providers</a> : \$18,400 member/\$36,800 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 limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, drug discount, coupon or copay cards for prescription drugs, non-authorization penalties and health care 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> .
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of <a href="#">preferred providers</a> , see <a href="http://www.healthnet.com/findaprovider">www.healthnet.com/findaprovider</a> or call 1-800-522-0088.	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 <a href="#">plan's 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.
<b>Do you need a referral to see a specialist?</b>	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 Preferred 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$75 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/</a> immunization	No charge <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab-\$40 <a href="#">copay</a> /visit X-ray-\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Requires <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .
If you need drugs to treat your illness or condition.  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthnet.com">www.healthnet.com</a>	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> /retail order <a href="#">deductible</a> does not apply \$40 <a href="#">copay</a> /mail order <a href="#">deductible</a> does not apply	Not covered	Pharmacy <a href="#">deductible</a> : \$300 member/\$600 family per calendar year (applies to Tiers 2-4). Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. <a href="#">Prior authorization</a> required for select drugs. If <a href="#">prior authorization</a> is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.
	Preferred brand drugs (Tier 2)	\$65 <a href="#">copay</a> /retail order \$130 <a href="#">copay</a> /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$100 <a href="#">copay</a> /retail order \$200 <a href="#">copay</a> /mail order	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	40% <a href="#">coinsurance</a> up to \$250 per prescription	Not covered	Pharmacy <a href="#">deductible</a> : \$300 member/\$600 family per calendar year (applies to Tiers 2-4). Supply/order: 30 day supply from specialty pharmacy except where quantity limits apply. <a href="#">Prior authorization</a> required for select drugs. If <a href="#">prior authorization</a> is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.

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

Common Medical Event	Services You May Need	What You Will Pay Preferred 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/ASC-40% <a href="#">coinsurance</a> Services other than surgery-40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some outpatient surgical procedures require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Medical, mental health & substance use disorders- Facility-40% <a href="#">coinsurance</a> Professional services-40% <a href="#">coinsurance</a>	Medical, mental health & substance use disorders- Facility-40% <a href="#">coinsurance</a> Professional services-40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	Medical, mental health & substance use disorders-40% <a href="#">coinsurance</a>	Medical, mental health & substance use disorders-40% <a href="#">coinsurance</a>	Non-emergencies require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Urgent care</a>	Medical, mental health & substance use disorders-\$50 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	Medical, mental health & substance use disorders-50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> services which meet the criteria for emergency care are payable at the <a href="#">preferred provider</a> level of coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Non-emergencies require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some services received while admitted to the hospital require <a href="#">prior authorization</a> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-\$50 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply Other than office visit-40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained for services other than office visits, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .
	Inpatient services	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Non-emergencies require <a href="#">prior authorization</a> . If <a href="#">prior authorization</a> is not obtained, a \$250 penalty will apply for <a href="#">preferred providers</a> ; \$500 penalty will apply <a href="#">out-of-network</a> .

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

Common Medical Event	Services You May Need	What You Will Pay Preferred 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 are pregnant	Office visits	Prenatal/Postnatal-\$50 <u><a href="#">copay</a></u> /visit <u><a href="#">deductible</a></u> does not apply	50% <u><a href="#">coinsurance</a></u>	<u><a href="#">Cost sharing</a></u> does not apply for <u><a href="#">preventive services</a></u> .
	Childbirth/delivery professional services	40% <u><a href="#">coinsurance</a></u>	50% <u><a href="#">coinsurance</a></u>	None
	Childbirth/delivery facility services	40% <u><a href="#">coinsurance</a></u>	50% <u><a href="#">coinsurance</a></u>	None
If you need help recovering or have other special health needs	<u><a href="#">Home health care</a></u>	40% <u><a href="#">coinsurance</a></u>	50% <u><a href="#">coinsurance</a></u>	Limited to 100 visits per calendar year combined between <u><a href="#">preferred providers</a></u> and <u><a href="#">out-of-network</a></u> . Home health <u><a href="#">rehabilitative/habilitative</a></u> services are limited to 100 separate visits per calendar year. Some services require <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .
	<u><a href="#">Rehabilitation services</a></u>	\$50 <u><a href="#">copay</a></u> /visit <u><a href="#">deductible</a></u> does not apply	50% <u><a href="#">coinsurance</a></u>	Some services require <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .
	<u><a href="#">Habilitation services</a></u>	\$50 <u><a href="#">copay</a></u> /visit <u><a href="#">deductible</a></u> does not apply	50% <u><a href="#">coinsurance</a></u>	Some services require <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .
	<u><a href="#">Skilled nursing center</a></u>	40% <u><a href="#">coinsurance</a></u>	50% <u><a href="#">coinsurance</a></u>	Requires <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .
	<u><a href="#">Durable medical equipment</a></u>	40% <u><a href="#">coinsurance</a></u>	50% <u><a href="#">coinsurance</a></u>	Some services require <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .
	<u><a href="#">Hospice services</a></u>	No charge <u><a href="#">deductible</a></u> does not apply	50% <u><a href="#">coinsurance</a></u>	Requires <u><a href="#">prior authorization</a></u> . If <u><a href="#">prior authorization</a></u> is not obtained, a \$250 penalty will apply for <u><a href="#">preferred providers</a></u> ; \$500 penalty will apply <u><a href="#">out-of-network</a></u> .

\* 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 Preferred 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 your child needs dental or eye care	Children's eye exam	No charge <u>deductible</u> does not apply	Not covered	Limited to 1 visit every 12 months.
	Children's glasses	No charge <u>deductible</u> does not apply	Not covered	Provider selected frames; 1 every 12 months.
	Children's dental check-up	No charge <u>deductible</u> does not apply	10% <u>coinsurance</u> <u>deductible</u> does not apply	Limited to 1 check-up every 6 months.

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</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-termination of pregnancy and related services are covered in full</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>
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#### 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](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](http://Marketplace). For more information about the [Marketplace](http://Marketplace), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

## 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](http://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](http://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](http://www.dmhc.ca.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at the contact information provided above.

## 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, kwijjigo 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)

▪ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,700
▪ <a href="#">Specialist copayment</a>	\$75
▪ Hospital (facility) <a href="#">coinsurance</a>	40%
▪ Other <a href="#">coinsurance</a>	40%

**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*)

**Total Example Cost** **\$12,700**

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

Cost Sharing	
Deductibles	\$1,700
Copayments	\$300
Coinsurance	\$4,000

**What isn't covered**

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,060</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>	\$1,700
▪ <a href="#">Specialist copayment</a>	\$75
▪ Hospital (facility) <a href="#">coinsurance</a>	40%
▪ Other <a href="#">coinsurance</a>	40%

**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*)

**Total Example Cost** **\$5,600**

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

Cost Sharing	
Deductibles	\$1,500
Copayments	\$1,300
Coinsurance	\$0

**What isn't covered**

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</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>	\$1,700
▪ <a href="#">Specialist copayment</a>	\$75
▪ Hospital (facility) <a href="#">coinsurance</a>	40%
▪ Other <a href="#">coinsurance</a>	40%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** **\$2,800**

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

Cost Sharing	
Deductibles	\$1,700
Copayments	\$400
Coinsurance	\$200

**What isn't covered**

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>

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

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

**Health Net:**

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

If you need these services, contact the Health Net 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)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call one of the phone numbers above or write to:

Health Net

Post Office Box 9103, Van Nuys, California 91409-9103

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769

- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631
- Electronically: Send an email to [SM\\_Section1557Coord@centene.com](mailto:SM_Section1557Coord@centene.com) This notice is available at Health Net website:  
[https://www.healthnet.com/en\\_us/disclaimers/legal/non-discrimination-notice.html](https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html)

If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, 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).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

FLY065732EP00 (05/25)

## **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 المترجمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفوري لخطة الأفراد والعائلة: 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). أو المنشروقات الصغيرة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

## **Armenian**

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

विना शुल्क भाषा सेवाएं। आप एक दुर्भागिया प्राप्ति कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। नदद 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 वाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल विजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माइयन से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

## **Hmong**

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

## Japanese

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただぐか、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

សេវាការសារដោយភតិតត្រូវ។ លេកអ្នកអាជីវិតមុខបកប្រែត្រាប់ពាក្យរៀងកសាងរីលើកម្បុកតាមសារសេវាកម្បុក។ ស្រាប់ជីវិយ សុខបារិតុស្តីថ្ងៃទៅការអេប្បីមុខលីនិងអេប្បីតាមលទ្ធផលនៃការប្រើប្រាស់លេកអ្នក ប្រើបាយស្តីថ្ងៃទៅការអេប្បី Off Exchange ឬសំគាល់តាមរូបរាង:បុគ្គល ីនិងក្រុងសារ (IFP) តាមរយៈលេខ: 1-800-839-2172 (TTY: 711)។ ស្រាប់ជីវិយផ្លូវការនៃក្រុងសារ (On Exchange) ឬសំគាល់ IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ប្រើបាយការអេប្បីកម្បុខាតកុចាបាយ:លេខ 1-888-926-5133 (TTY: 711)។ ស្រាប់គ្រប់គ្រាងការអេប្បី: Health Net សុខបារិតុស្តីថ្ងៃទៅការអេប្បី 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 가드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

## Navajo

Doo bájh ilinigóó saad bee háká ada’llyeed. Ata’ halne’igii da la’ ná hádidóot’|||. Naaltsoos da t’áá shi shizaad k’ehjí shíchí’ yidooltaah nínízingo t’áá ná ákodoolníi. Ákót’éego shiká a’doowoł nínízingo Customer Contact Center hoolyéhíjí’ hodilínlíh nínaaltsoos nanlíntingo bee néého’ dolzinigíi hodoonlhíjí’ blikáá’ éí doodago kojí’ hólne’ Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhigíí kojí’ hólne’ IFP On Exchange 1-888-926-4988 (TTY: 711) éí doodago Small Business báhigíí kojí’ hólne’ -888-926-5133 (TTY: 711). Group Plans through Health Net báhigíí éí kojí’ hólne’ 1-800-522-0088 (TTY: 711).

## Persian (Farsi)

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

### **Punjabi (Punjabi)**

ਖਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸੀਏ 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 ਐਕਸਟੋਜ਼ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੋਈਫੇਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐਨ ਐਕਸਟੋਜ਼ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੇਲ ਬਿਜ਼ਨੇਸ 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-ugnido sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

### **Thai**

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้จ่ายได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์สูกค้าล้มพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาสำนักพัฒนาบุคคลและครอบครัวของกองทัพ (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรศัพท์ TTY: 711) สำหรับเขตแฟลิฟอร์นิบ โทรหาสำนักพัฒนาบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรศัพท์ TTY: 711) หรือ สำนักธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรศัพท์ TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรศัพท์ 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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