### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | $250 member through preferred providers; $250 member through out-of-network providers per calendar year combined. Three family members must satisfy their individual deductible in order to satisfy the family deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members satisfies the overall deductible.

Are there services covered before you meet your deductible? | Yes. Preventive care, primary care visits, specialist visits, prescription drugs, outpatient mental health/substance abuse services, prenatal office visits and children’s eye exams are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

Are there other deductibles for specific services? | Yes. $500/lifetime for infertility services. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan? | Combined medical/pharmacy limit: $1,500 member/$3,000 family through preferred providers; $5,000 member/ $10,000 family through out-of-network providers per calendar year combined. | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit? | Premiums, balance billing charges and healthcare 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](http://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? | No. | You can see the specialist you choose without a referral.
For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10/visit deductible does not apply</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge for covered services; deductible does not apply</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Requires prior authorization.</td>
</tr>
</tbody>
</table>

**If you need drugs to treat your illness or condition**

More information about prescription drug coverage is available at www.healthnet.com/ca_druglist.

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Preferred Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic drugs</td>
<td>$5/retail order</td>
<td>$5/retail order</td>
<td>Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior Authorization is required for select drugs. If you buy a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name and generic drug plus copay or coinsurance.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$5/retail order</td>
<td>$5/retail order</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$5/retail order</td>
<td>$5/retail order</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Self injectables-10% coinsurance Refer to the recommended drug list for other drugs considered specialty</td>
<td>Not covered</td>
<td>Up to $250 max copayment per prescription. Supply/order up to a 30 day supply specialty pharmacy except where quantity limits apply. Prior authorization required for select drugs. Self Injectable/Specialty drugs not covered Out of network.</td>
</tr>
</tbody>
</table>

**If you have outpatient surgery**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Preferred Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>May require prior authorization.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Preferred Provider (You will pay the least): $50/visit + 10% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): $50/visit + 10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50/visit + 10% coinsurance</td>
<td>$50/visit + 10% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office-$10/visit deductible does not apply Other than office-No charge deductible does not apply</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>Prenatal-No charge deductible does not apply Postnatal-10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.healthnet.com](http://www.healthnet.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Preferred Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Birth through age 2- No charge deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery
- Infertility treatment-limited to an annual limit of $2,500 and limited to a lifetime limit of $10,000.

**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, 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, 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 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. 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 1-800-522-0088.
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.
### 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.

<table>
<thead>
<tr>
<th>Example</th>
<th>Description</th>
<th>Total Example Cost</th>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peg is Having a Baby</td>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>$12,800</td>
<td>Deductibles $250, Copayments $40, Coinsurance $1,000</td>
<td>Limits or exclusions $60</td>
</tr>
<tr>
<td>Managing Joe’s type 2 Diabetes</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>$7,400</td>
<td>Deductibles $250, Copayments $400, Coinsurance $400</td>
<td>Limits or exclusions $60</td>
</tr>
<tr>
<td>Mia’s Simple Fracture</td>
<td>(in-network emergency room visit and follow up care)</td>
<td>$2,500</td>
<td>Deductibles $250, Copayments $30, Coinsurance $200</td>
<td>Limits or exclusions $0</td>
</tr>
</tbody>
</table>

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).

English

Arabic

Armenian

Chinese
免费语言服务。您可使用口译员服务。您可请人将文件念给您听并请我们将其翻译成您的语言寄给您。如需协助，请拨打您会员卡上的电话号码与客户服务中心联络或者拨打健康保险交易市场外的 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，請拨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 दुभाबषया प्रास कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़ा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैक्सली प्लान (आईएफपी) ऑफ एक्सचेज 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफॉर्निया बाजारी के लिए, आईएफपी ऑफ एक्सचेज 1-888-926-4988 (TTY: 711) या स्मार्ट विकल्प 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से गुप्त प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Panjabi (Punjabi)

ਬਿਨਾਂ ਬਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਖਾਸੀ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰਨ ਦੀ ਸਿਦ੍ਹਾਂਤ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸਾ
ਬੱਚ ਪੜ੍ਹ ਲਈ ਸੁਣਾਏ ਜਾ ਸਿਦ੍ਹਾਂਤ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਨੋ ਰੱਖ ਲੈ ਗਾਹੀ ਸੰਸਾਰੀ ਗਾਹੀ ਸੰਸਾਰੀ (IFP) ਨੌ ਨੋ ਰੱਖ ਲੈ 
ਤੁਹਾਕੀਬਾਦੀਆਂ ਬਾਅਦ ਮਿਟਾਈਆਂ ਮੇਲਾ ਦੇ ਬਾਅਦ ਕਾਮ ਹੋਏ। IFP ਨੌ ਨੋ ਰੱਖ ਲੈ 
ਮਾਰਬਿਟਪਲੇਸ ਲਈ, IFP ਨੌ ਨੋ ਰੱਖ ਲੈ 1-888-926-4988 (TTY: 711) ਨੋ ਰੱਖ ਲੈ ਜਾਂ 
1-800-522-0088 (TTY: 711) ਨੋ ਰੱਖ ਲੈ। 

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 
участвующих 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 

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 babasahan sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa 
umeron ng nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya 

Thai

ไม่มีค่าบริการการด้านภาษา คุณสามารถใช้ผู้พูดได้ คุณสามารถให้ยืมเอกสารให้พัฒนาเป็นภาษาของคุณได้ หากต้องการความช่วย 
เหลือ โทรที่ศูนย์ข้อมูลเพื่อส่งต่อให้ที่เหมาะสมยังบริการประจำตัวของคุณ หรือโทรที่แผนบุคคลและครอบครัวของเอกชน 
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