

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

_____	Primary care visit to treat an injury or illness	\$15 copay /visit	Not covered	None

* For more information about limitations and exceptions, see the _____ or policy document at _____.

	Facility fee (e.g., ambulatory surgery center)	Hospital/ASC-No charge Services other than surgery-No charge	Not covered	Requires prior authorization .
	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	Medical, mental health & substance use disorders-\$75 copay /visit	Covered at In-Network cost-share for emergencies only	Copay waived if admitted into the hospital.
	Emergency medical transportation	Medical, mental health & substance use disorders-No charge		None
	Urgent care	Medical-\$20 copay /visit Mental health & substance use disorders-No charge		None
	Facility fee (e.g., hospital room)	No charge	Not covered	Requires prior authorization .
	Physician/surgeon fees	No charge	Not covered	None
	Outpatient services	Office-individual therapy session-No charge group therapy session-No charge Other than office-No charge	Not covered	Requires prior authorization except for office visits.
	Inpatient services	No charge	Not covered	Requires prior authorization .
	Office visits	Prenatal/Postnatal-No charge	Not covered	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

* For more information about limitations and exceptions, see the ____ or policy document at _____.

Not covered

Requires [prior authorization](#).

at _____.

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.

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. 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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare (f) 27 () 142if Bn7 0 TP (m

* For more information about limitations and exceptions, see the ____ or policy document at _____.

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.

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$0

Specialist office visits (*prenatal care*)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (*ultrasounds and blood work*)

Nondiscrimination Notice

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

HEALTH NET:

Characteristics listed above can be a source of discrimination. Health Net's Customer Contact Center at 1-800-444-4444 and toll-free number 1-800-444-4444 are available to you. A source of discrimination can also be a source of harassment. Email: 1-800-444-4444

Health Net of California, Health Net Life Insurance Company of California
1000 N. Main St.

10/1/2024

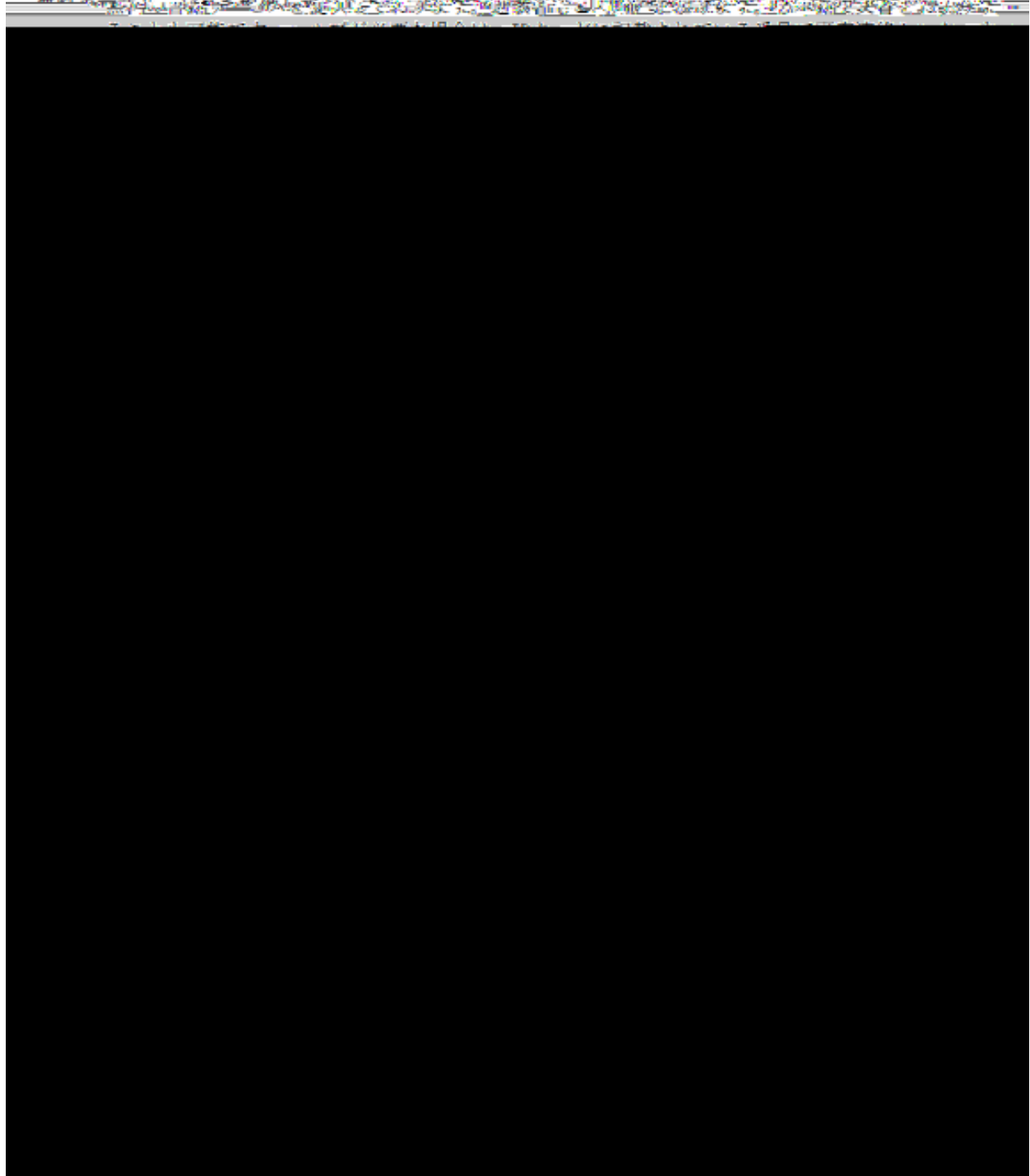
Email: 1-800-444-4444 or 1-800-444-4444
Nondiscrimination Complaints at 1-800-444-4444

If you are not satisfied with a decision or it has been more than 60 days since you filed a complaint with Health Net of California, you may file an independent administrative complaint with the Department of Health Care Services. You may file a complaint form at <https://www.dhs.ca.gov/ohca> or call 1-800-444-4444.

If you have been discriminated against because of race, color, national origin, ancestry, religion, sex, or gender, you may file a civil rights complaint with the Department of Health and Human Services or the Department of Health and Human Services, Independence Avenue, Room 400, HH Building, San Francisco, CA 94133.

Complaint forms are available at <https://www.dhs.ca.gov/ohca> or call 1-800-444-4444.

Japanese



Vietnam

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Ngày: _____ Số điện thoại: _____
Địa chỉ: _____
Họ Tên: _____
Số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (HP)

