



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 [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) 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
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	There is no <a href="#">deductible</a> .	There is no <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,500 member/\$15,000 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of <b>preferred providers</b> , see <a href="http://www.healthnet.com/providersearch">www.healthnet.com/providersearch</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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes. Requires written <a href="#">prior authorization</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">prior authorization</a> .
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab-\$40 <a href="#">copay</a> /visit X-ray-\$50 <a href="#">copay</a> /visit	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	\$325 <a href="#">copay</a> /procedure	Not covered	Requires <a href="#">prior authorization</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)	\$15 <a href="#">copay</a> /retail order \$30 <a href="#">copay</a> /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. <a href="#">Prior authorization</a> is required for select drugs.
	Preferred brand drugs (Tier 2)	\$50 <a href="#">copay</a> /retail order \$125 <a href="#">copay</a> /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$70 <a href="#">copay</a> /retail order \$175 <a href="#">copay</a> /mail order	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Self injectables- 30% <a href="#">coinsurance</a> 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. <a href="#">Prior authorization</a> 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](http://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
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Hospital-\$1,200 <a href="#">copay</a> /admission ASC-\$480 <a href="#">copay</a> /admission	Not covered	Requires <a href="#">prior authorization</a> .
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Medical, mental health & substance use disorders-Facility-\$325 <a href="#">copay</a> /visit Professional-No charge	Medical, mental health & substance use disorders-Facility-\$325 <a href="#">copay</a> /visit Professional-No charge	<a href="#">Copay</a> waived if admitted into the hospital. Out-of-network services must meet the criteria for emergency care.
	<a href="#">Emergency medical transportation</a>	Medical, mental health & substance use disorders-\$325 <a href="#">copay</a> /transport	Medical, mental health & substance use disorders-\$325 <a href="#">copay</a> /transport	Out-of-network services must meet the criteria for emergency care.
	<a href="#">Urgent care</a>	Medical-\$60 <a href="#">copay</a> /visit Mental health and substance use disorders-\$40 <a href="#">copay</a> /visit	Medical-\$60 <a href="#">copay</a> /visit Mental health and substance use disorders-\$40 <a href="#">copay</a> /visit	Out-of-network services must meet the criteria for emergency care.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$750 <a href="#">copay</a> /day	Not covered	5 day max copay per admission. Requires <a href="#">prior authorization</a> .
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office-individual therapy session-\$40 <a href="#">copay</a> /visit group therapy session-\$20 <a href="#">copay</a> /visit Other than office-No charge	Not covered	Requires <a href="#">prior authorization</a> except for office visits.
	Inpatient services	\$750 <a href="#">copay</a> /day	Not covered	5 day max copay per admission. Requires <a href="#">prior authorization</a> .
<b>If you are pregnant</b>	Office visits	Prenatal-\$40 <a href="#">copay</a> /visit Postnatal-\$40 <a href="#">copay</a> /visit	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	\$750 <a href="#">copay</a> /day	Not covered	5 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	<a href="#">Home health care</a>	\$40 <a href="#">copay</a> /visit	Not covered	Limited to 100 intermittent visits each calendar year. Requires <a href="#">prior authorization</a> .
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit	Not covered	Requires <a href="#">prior authorization</a> .
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit	Not covered	
	<a href="#">Skilled nursing center</a>	\$25 <a href="#">copay</a> /day	Not covered	Requires <a href="#">prior authorization</a> .
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	Requires <a href="#">prior authorization</a> .
	<a href="#">Hospice services</a>	No charge	Not covered	Requires <a href="#">prior authorization</a> .
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](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](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Health Net's Customer Contact Center at 1-800-522-0088, 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, 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.*

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	▪ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	▪ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
▪ <a href="#">Specialist copayment</a>	\$60	▪ <a href="#">Specialist copayment</a>	\$60	▪ <a href="#">Specialist copayment</a>	\$60
▪ Hospital (facility) <a href="#">copayment</a>	\$750	▪ Hospital (facility) <a href="#">copayment</a>	\$750	▪ Hospital (facility) <a href="#">copayment</a>	\$750
▪ Other <a href="#">copayment</a>	\$40	▪ Other <a href="#">copayment</a>	\$40	▪ Other <a href="#">copayment</a>	\$40
<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>  <a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$1,600	Copayments	\$1,300	Copayments	\$1,300
Coinsurance	\$0	Coinsurance	\$300	Coinsurance	\$100
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,660</b>	<b>The total Joe would pay is</b>	<b>\$1,620</b>	<b>The total Mia would pay is</b>	<b>\$1,400</b>

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