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--088. 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?	$2,250 member / $4,500 family per calendar year.	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 meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary care visit, specialist visit, preventive care, urgent care, some outpatient mental health care, pre and postnatal visits, home health care, rehabilitation and habilitation services, hospice services, pediatric vision & dental 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/.
Are there other deductibles for specific services?	Yes. $200 member/$400 family per calendar year for brand name drugs. 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?	$7,350 member / $14,700 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, 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 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 prior authorization.	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		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First visit- No charge Visits 2+ - $20/visit Deductible does not apply	Not covered	——————none——————
	Specialist visit	$45/visit Deductible does not apply	Not covered	Requires prior authorization.
	Preventive care/screening/ immunization	No charge Deductible does not apply	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)	X-ray - $50/visit Lab - $40/visit	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	$300/procedure	Not covered	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthnet.com/ca_druglist	Generic drugs	$20/retail order $40/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. 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 for the generic. $200 member/$400 family per calendar year for brand name drugs
	Preferred brand drugs	$60/retail order $150/mail order	Not covered	
	Non-preferred brand drugs	$70/retail order $175/mail order non-preferred brands only	Not covered	
	Specialty drugs	Self injectables- 50% coinsurance Refer to the recommended drug list for other drugs considered specialty	Not covered	Maximum out-of-pocket cost per 30 day script $250 after deductible. Prior Authorization is required for select drugs. Quantity limits may apply for select drugs. Supply/order: up to a 30 day supply filled by specialty pharmacy.

* 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		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital -50% coinsurance ASC - 40% coinsurance	Not covered	Requires prior authorization.
	Physician/surgeon fees	Physician-$0 Surgeon-40% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$300/visit	$300/visit	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	$300/transport	$300/transport	——————none——————
	Urgent care	$45/visit Deductible does not apply	$45/visit Deductible does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	Not covered	Requires prior authorization.
	Physician/surgeon fees	Physician-$0 Surgeon-50% coinsurance	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office- First visit- No charge Visits 2+- $20/visit- individual therapy $10/visit- group therapy session Deductible does not apply Other than office- No charge Deductible does not apply	Not covered	Prior authorization required except for office visits.
	Inpatient services	50% coinsurance	Not covered	Requires prior authorization.
If you are pregnant	Office visits	$20/visit Deductible does not apply	Not covered	Prenatal and postnatal preventive services are covered under preventive care.
	Childbirth/delivery professional services	50% coinsurance	Not covered	——————none——————
	Childbirth/delivery facility services	50% coinsurance	Not covered	——————none——————

* 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		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$20/visit Deductible does not apply	Not covered	Limited to 100 visits each calendar year. Requires prior authorization.
	Rehabilitation services	$20/visit Deductible does not apply	Not covered	Requires prior authorization.
	Habilitation services	$20/visit Deductible does not apply	Not covered	Requires prior authorization.
	Skilled nursing care	$25/day	Not covered	Requires prior authorization.
	Durable medical equipment	50% coinsurance	Not covered	Corrective footwear is not covered. Requires prior authorization.
	Hospice services	No charge Deductible does not apply	Not covered	Requires prior authorization.
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 services
- 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
- Bariatric surgery
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

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

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 1-800-HMO-2219 or www.hmohelp.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

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.
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, kwiijigo holne' 1-800-522-0088.

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

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

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 plan's overall deductible	$2,250
Specialist copayment	$45
Hospital (facility) coinsurance	50%
Other copayment	$20

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$1,200
Coinsurance	$4,300
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$7,350**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,250
Specialist copayment	$45
Hospital (facility) coinsurance	50%
Other copayment	$20

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$2,300
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,360**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,250
Specialist copayment	$45
Hospital (facility) coinsurance	50%
Other copayment	$20

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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,400
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,740**

The plan would be responsible for the other costs of these EXAMPLE covered services.