



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 costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$200 per member / \$400 family per calendar year for brand name drugs (waived for tier 1 drugs). 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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,000 member / \$14,000 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 plan's <a href="#">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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes. Requires written prior authorization.	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		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$50/visit	Not covered	—————none—————
	<a href="#">Specialist</a> visit	\$70/visit	Not covered	Requires prior authorization.
	<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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthnet.com/ca/druglist">www.healthnet.com/ca/druglist</a>	Generic drugs	\$15/retail order \$30/mail order all generics except specialty generics/pharmacy deductible does not apply	Not covered	Pharmacy deductible applies \$200 per member / \$400 family per calendar year for brand name drugs (waived for tier 1 drugs). Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior Authorization is required for select drugs.
	Preferred brand drugs	\$50/retail order \$125/mail order	Not covered	
	Non-preferred brand drugs	\$70/retail order \$175/mail order non-preferred brands only	Not covered	
	<a href="#">Specialty drugs</a>	Self injectables- 40% coinsurance Refer to the recommended drug list for other drugs considered specialty	Not covered	Pharmacy deductible applies \$200 per member / \$400 family. Supply/order: up to a 30 day supply filled by specialty pharmacy. Prior Authorization is required for select drugs. Quantity limits may apply for select drugs.  Maximum out-of-pocket cost per 30 day script: \$250.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Hospital-\$1,200/procedure ASC-\$480/procedure	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	—————none—————

\* 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		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 immediate medical attention	<a href="#">Emergency room care</a>	\$300/visit	\$300/visit	Cost sharing waived if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	\$300/transport	\$300/transport	—————none—————
	<a href="#">Urgent care</a>	\$70/visit	\$70/visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750/day	Not covered	4 day copay max per admission. Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$50/visit-individual therapy session \$25/visit-group therapy session Other than office visit- No charge	Not covered	Prior authorization required except for office visits.
	Inpatient services	\$750/day	Not covered	4 day copay max per admission. Requires prior authorization.
If you are pregnant	Office visits	\$50/visit	Not covered	Prenatal and postnatal preventive services are covered under preventive care.
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	\$750/day	Not covered	4 day copay max per admission. Coverage includes abortion services.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$50/visit	Not covered	Limited to 100 visits each calendar year. Requires prior authorization.
	<a href="#">Rehabilitation services</a>	\$50/visit	Not covered	Requires prior authorization.
	<a href="#">Habilitation services</a>	\$50/visit	Not covered	Requires prior authorization.
	<a href="#">Skilled nursing care</a>	\$25/day	Not covered	Requires prior authorization.
	<a href="#">Durable medical equipment</a>	40% coinsurance	Not covered	Requires prior authorization.
	<a href="#">Hospice services</a>	No charge	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—————

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

## 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)

## 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 1-800-HMO-2219 or [www.hmohelp.ca.gov](http://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](http://www.dol.gov/ebsa/healthreform)

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

### 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, kwijigo holne' 1-800-522-0088.

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*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)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$50

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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$50

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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$2,300
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,260</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$50

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

<b>Total Example Cost</b>	<b>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,400
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,420</b>