



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/policy/sbg_gold_80_value_ppo_750_15_alt_2020 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 <https://www.healthcare.gov/sbc-glossary/> 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?	For preferred providers \$750 per person / \$1,500 per family. \$2,250 per person / \$4,500 per family for out-of-network providers per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care office visits, tier 1 drugs (preferred generic), chiropractic services, acupuncture services, outpatient mental health & substance use disorder office visits, outpatient rehabilitation & habilitation, hospice, pediatric dental and vision care are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers \$7,600 per person / \$15,200 per family; for out-of-network providers \$15,200 per person / \$30,400 per family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> charges, expenses paid for chiropractic services, drug discount, coupon or copay cards for prescription drugs, penalties for non-certification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Preferred 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	\$15/visit deductible does not apply	50% coinsurance	—————none—————
	Specialist visit	\$30/visit	50% coinsurance	—————none—————
	Preventive care/screening/immunization	No charge	50% coinsurance	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-\$25/visit Lab-\$25/visit	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	\$150/procedure	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthnet.com/ca_druglist	Preferred generic drugs (tier 1)	\$15/retail order deductible does not apply \$30/mail order deductible does not apply	Not covered	Medical deductible applies (waived for tier 1 drugs). Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. If prior authorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.
	Non-preferred generic and preferred brand drugs (tier 2)	\$40/retail order \$80/mail order	Not covered	
	Non-preferred brand drugs (tier 3)	\$70/retail order \$140/mail order	Not covered	
	Specialty drugs (tier 4)	30% coinsurance to maximum of \$250 per 30 day prescription	Not covered	Medical deductible applies. Supply/order: 30 day supply from specialty pharmacy except where quantity limits apply. Prior authorization is required for select drugs. If prior authorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.

* 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
		Preferred 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)	30% coinsurance	50% coinsurance	Some outpatient surgical procedures require certification or a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Some outpatient surgical procedures require certification.
If you need immediate medical attention	Emergency room care	\$250/visit	\$250/visit	Copay waived if admitted into the hospital.
	Emergency medical transportation	\$250/transport	\$250/transport	—————none—————
	Urgent care	\$30/visit	50% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	If certification is not obtained in a non-emergency a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Certification is required for a hospital stay and some services received while admitted to the hospital.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-\$15 deductible does not apply Other than office visit-\$0 (deductible applies)	50% coinsurance	Certification is not required for outpatient services for mental health and substance use disorder diagnoses except for reconstructive surgery. If certification is required but not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Inpatient services	30% coinsurance	50% coinsurance	If certification is not obtained in a non-emergency a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	50% coinsurance	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. CA prenatal screening program is covered at no charge both in and out-of-network.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	—————none—————
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	—————none—————
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 100 visits per calendar year, combined between preferred provider network and out-of-network visits (rehabilitative and habilitative home health services are each limited to separate 100 visit limits each calendar year). Certification is required for some services or a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Rehabilitation services	\$15/visit deductible does not apply	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Habilitation services	\$15/visit deductible does not apply	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Skilled nursing care	30% coinsurance	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
	Durable medical equipment	30% coinsurance	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.

* 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
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	50% coinsurance	Certification is required for hospice facility admissions only. If certification is not obtained a \$250 penalty will apply through the preferred provider network, a \$500 penalty will apply out-of-network.
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	10% coinsurance deductible does not apply	Limited to 1 check-up every 6 months.

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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs (exclusion does not apply to preventive care behavioral interventions)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Abortion services • Acupuncture (covered when medically necessary) 	<ul style="list-style-type: none"> • Bariatric surgery (covered through the preferred provider network if medically necessary) • Chiropractic care (limited to 12 visits per calendar year) 	<ul style="list-style-type: none"> • 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. 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.

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

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.

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](#) \$750
- [Specialist copayment](#) \$30
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$700
Coinsurance	\$3,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,910

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$30
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,600
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,910

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$30
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,800
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,120