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_ppo_gold_value_2019 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?	$750 per person / $1,500 per family through preferred providers. $2,250 per person / $4,500 per family through out-of-network providers.	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. Preventive care services, primary care, prenatal care, chiropractic care, hospice services, outpatient mental health & substance abuse office visits; rehabilitation & habilitation services, pediatric vision & dental care, acupuncture and tier 1 drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers $7,150 per person / $14,300 per family. For out-of-network providers $14,300 per person / $28,600 per 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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, expenses paid for chiropractic services, expenses paid for infertility services, penalties for non-certification 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?	No.	You can see the specialist you choose without a referral.

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	$10/visit deductible does not apply	50% coinsurance	——————none——————
	Specialist visit	$30/visit	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	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	Diagnostic test (x-ray, blood work)	$20/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)	$10/retail order $20/mail order deductible does not apply	Not covered	Supply/order: up to 30 day (retail); 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)	$25/retail order $50/mail order	Not covered	
	Non-preferred brand drugs (tier 3)	$50/retail order $100/mail order	Not covered	
	Specialty drugs (tier 4)	30% co-ins up to a maximum of $250 per 30 day script	Not covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital – 30% coinsurance Ambulatory surgical center - 20% 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.

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)	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Some outpatient surgical procedures require certification.
If you need immediate medical attention	Emergency room care	Facility - $250/visit Professional services – no charge	Facility - $250/visit Professional services – no charge	——————none——————
	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	Certification is required for a non-emergency hospital facility stay 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	Certification is required for a non-emergency 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 - $10/visit deductible does not apply Other than office visit – 0% coinsurance	50% coinsurance	Certification is required for some outpatient mental health, behavioral health, and substance abuse services (not including regular office visits) or a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.
	Inpatient services	30% coinsurance	50% coinsurance	Certification is required for a non-emergency inpatient stay or a $250 penalty will apply through the preferred provider network, a $500 penalty will apply out-of-network.
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	Coverage includes abortion services.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Coverage includes abortion services.

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 need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Limited to 100 visits per calendar year (rehabilitative and habilitative home health services are each limited to separate 100 visit limits per calendar year). Certification is required for some services or a $250 penalty will apply.
	Rehabilitation services	$10/visit deductible does not apply	Not covered	If certification is not obtained a $250 penalty will apply.
	Habilitation services	$10/visit deductible does not apply	Not covered	If certification is not obtained a $250 penalty will apply.
	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	Diabetic equipment (including footwear) and prosthesis only - 50% coinsurance	Orthotics, corrective footwear and all other durable medical equipment are not covered out-of-network. If certification is not obtained a $250 penalty will apply through the preferred provider network.
	Hospice services	No charge	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 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 one check-up every six 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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (exclusion does not apply to preventive care behavioral interventions)

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

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 (covered through the preferred provider network if medically necessary)	• Chiropractic care (limited to 12 visits per calendar year) • Infertility treatment (limited to a lifetime limit of $2,000. Infertility drugs are limited to a separate lifetime limit of $2,000.In vitro fertilization & zygote intrafallopian transfer are not covered).	• 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.

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, 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	$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,610**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1,100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,410**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,420**

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