



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 1-800-522-0088. 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 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 ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	You will have to meet the deductible before the plan pays for any services.
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 ?	\$6,000 member / \$12,000 per family through Salud. \$1,500 member / \$4,500 family through SIMNSA. Salud & SIMNSA tiers cross accumulate.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have 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 , infertility services 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
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5/visit	\$35/visit	\$5/visit	-----none-----
	Specialist visit	\$5/visit	\$55/visit	\$5/visit	Requires prior authorization.
	Preventive care/screening/immunization	No charge	No charge	No charge	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)	No charge	X-ray - \$50 Lab - \$40	No charge	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	\$300/procedure	No charge	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	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	\$15/retail order \$30/mail order	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30 day supply filled by specialty pharmacy. Maximum out-of-pocket cost per 30 day script through Salud Network: \$250
	Preferred brand drugs		\$50/retail order \$125/mail order		
	Non-preferred brand drugs		\$70/retail order \$175/mail order		
	Specialty drugs	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	30% co-ins	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Hospital- \$1,200/procedure ASC-\$480/procedure	No charge	Requires prior authorization.

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com EZE_NO_YO4_BDK_UH_1AL

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
	Physician/surgeon fees	No charge	No charge	No charge	-----none-----
If you need immediate medical attention	Emergency room care	\$10/visit	\$300/visit	\$10/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge	\$300/transport	No charge	-----none-----
	Urgent care	\$10/visit	\$55/visit	\$10/visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$750 per day	No charge	3 day maximum copayment per admission. Requires prior authorization.
	Physician/surgeon fees	No charge	No charge	No charge	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$5/visit Other than office- No charge	Office-\$35/visit- individual therapy session \$17.50/visit- group therapy session Other than office- No charge	Office-\$5/visit Other than office- No charge	Prior authorization required except for office visits.
	Inpatient services	No charge	\$750 per day	No charge	3 day maximum copayment per admission. Requires prior authorization.
If you are pregnant	Office visits	No charge	\$35/visit	No charge	Prenatal and postnatal preventive services are covered under preventive care.
	Childbirth/delivery professional services	No charge	No charge	No charge	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	\$750 per day	No charge	3 day maximum copayment per admission. Coverage includes abortion services. Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	Not covered	\$35/visit	Not covered	Limited to 100 visits per calendar year. Requires prior authorization.
	Rehabilitation services	\$5/visit	\$35/visit	\$5/visit	Requires prior authorization.
	Habilitation services	\$5/visit	\$35/visit	\$5/visit	Requires prior authorization.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
	Skilled nursing care	No charge	\$25/day	No charge	Requires prior authorization.
	Durable medical equipment	No charge	30% co-ins	No charge	Requires prior authorization.
	Hospice services	No charge	No charge	No charge	Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	Not covered	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	Not covered	No charge	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	Not covered	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](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • 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 |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|
| <ul style="list-style-type: none"> • Acupuncture (covered when medically necessary) • Bariatric surgery | <ul style="list-style-type: none"> • Infertility treatment • Routine eye care (Adult) |
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* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com EZE_NO_YO4_BDK_UH_1AL

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, 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.*-----



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](#) \$55
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$35

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

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](#) \$55
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$35

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	\$0
Copayments	\$2,100
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,660

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$55
- Hospital (facility) [copayment](#) \$750
- Other [copayment](#) \$35

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	\$0
Copayments	\$1,300
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,310