



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 ?	There is no deductible .	There is no deductible .
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 ?	\$1,750 per member / \$3,500 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 , the overall family out-of-pocket limit must be 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
		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	\$10 copay /visit	Not covered	None
	Specialist visit	\$30 copay /visit	Not covered	Requires preauthorization .
	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 copay /visit	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	\$150 copay /procedure	Not covered	Requires preauthorization .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhealthnetca.com/druglist	Generic drugs	\$5 copay /retail order \$10 copay /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. Preauthorization is required for select drugs.
	Preferred brand drugs	\$30 copay /retail order \$75 copay /mail order	Not covered	
	Non-preferred brand drugs	\$50 copay /retail order \$125 copay /mail order	Not covered	
	Specialty drugs	Self injectables- 30% coinsurance Refer to the recommended drug list for other drugs considered specialty	Not covered	Supply/order: up to a 30 day supply filled by specialty pharmacy. Preauthorization is required for select drugs. Quantity limits may apply for select drugs. Maximum out-of-pocket cost per 30 day script: \$250
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital- \$150 copay /admission ASC- \$60 copay /admission	Not covered	Requires preauthorization .
	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

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	Emergency room care	\$150 copay /visit	\$150 copay /visit	Copay waived if admitted into the hospital.
	Emergency medical transportation	\$150 copay /transport	\$150 copay /transport	None
	Urgent care	\$30 copay /visit	\$30 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay /day	Not covered	3 day max copay per admission. Requires preauthorization .
	Physician/surgeon fees	No charge	Not covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$10 copay /visit- individual therapy session \$5 copay /visit- group therapy session Other than office-No charge	Not covered	Preauthorization required except for office visits.
	Inpatient services	\$250 copay /day	Not covered	3 day max copay per admission. Requires preauthorization .
If you are pregnant	Office visits	\$10 copay /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	\$250 copay /day	Not covered	3 day max copay per admission. Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	\$10 copay /visit	Not covered	Limited to 100 intermittent visits each calendar year. Requires preauthorization .
	Rehabilitation services	\$10 copay /visit	Not covered	Requires preauthorization .
	Habilitation services	\$10 copay /visit	Not covered	Requires preauthorization .
	Skilled nursing care	\$25 copay /day	Not covered	Requires preauthorization .
	Durable medical equipment	10% coinsurance	Not covered	Requires preauthorization .
	Hospice services	No charge	Not covered	Requires preauthorization .
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
- 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
- Infertility services
- 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 Managed Health Care at 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhca.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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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.

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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	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$10

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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$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	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$10

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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$900

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$250
■ Other copayment	\$10

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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$620

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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