



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 <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 \$1,600 per member/\$3,200 per family; for out-of-network providers \$3,200 per member/\$6,400 per family per calendar year.	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 and services indicated in chart starting on Page 2.	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 \$4,000 per member/\$8,000 per family; for out-of-network providers \$8,000 per member/\$16,000 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 limits 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, drug discount, coupon or copay cards for prescription drugs, non-authorization penalties 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 Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge deductible does not apply	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)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	If prior authorization 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	Generic drugs (Tier 1)	\$15 copay /retail order \$30 copay /mail order	Not covered	Medical deductible applies to Tiers 1-4. 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.
	Preferred brand drugs (Tier 2)	\$30 copay /retail order \$60 copay /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$50 copay /retail order \$100 copay /mail order	Not covered	
	Specialty drugs (Tier 4)	20% coinsurance up to \$250 per prescription	Not covered	Medical deductible applies to Tiers 1-4. 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. Refer to the recommended drug list for drugs considered specialty.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Some outpatient surgical procedures require prior authorization or a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Some outpatient surgical procedures require prior authorization .
If you need immediate medical attention	Emergency room care	Medical, mental health & substance use disorders- Facility & professional services-20% coinsurance	Medical, mental health & substance use disorders- Facility & professional services-20% coinsurance	None
	Emergency medical transportation	Medical, mental health & substance use disorders- 20% coinsurance	Medical, mental health & substance use disorders- 20% coinsurance	If prior authorization 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 .
	Urgent care	Medical, mental health & substance use disorders- 20% coinsurance	Medical, mental health & substance use disorders- 50% coinsurance	Out-of-network services which meet the criteria for emergency care are payable at the preferred provider level of coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	If prior authorization 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	20% coinsurance	50% coinsurance	Prior authorization 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-20% coinsurance Other than office visit-20% coinsurance	50% coinsurance	If prior authorization is not obtained for services other than office visits, a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Inpatient services	20% coinsurance	50% coinsurance	If prior authorization 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 .

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	Prenatal-20% coinsurance Postnatal-20% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% 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). Prior authorization 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	20% coinsurance	50% coinsurance	If prior authorization is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing center	20% coinsurance	50% coinsurance	If prior authorization is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Durable medical equipment	20% coinsurance	50% coinsurance	If prior authorization is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Hospice services	\$0 after deductible has been met	50% coinsurance	Prior authorization is required for hospice facility admissions only. If prior authorization is not obtained 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 Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge deductible does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge deductible does not apply	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge deductible does not apply	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](#).)

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|--|---|--|
| <ul style="list-style-type: none"> • Chiropractic care • 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 |
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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"> • Abortion-termination of pregnancy and related services are covered in full • Acupuncture-covered when medically necessary | <ul style="list-style-type: none"> • Bariatric surgery-covered through the preferred provider network if medically necessary | <ul style="list-style-type: none"> • Routine eye care (Adult)-screenings/eye refraction for vision correction purposes |
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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.dmhc.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at the contact information provided above.

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](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$0
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,860

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$500
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,190

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,600
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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:

Cost Sharing	
Deductibles	\$1,600
Copayments	\$10
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,810

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