



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](http://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](http://www.healthnet.com) or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">preferred providers</a> \$1,600 per member/\$3,200 per family; for <a href="#">out-of-network providers</a> \$3,200 per member/\$6,400 per family per calendar year.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and services indicated in chart starting on Page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">preferred providers</a> \$4,000 per member/\$8,000 per family; for <a href="#">out-of-network providers</a> \$8,000 per member/\$16,000 per family per calendar year.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, drug discount, coupon or copay cards for prescription drugs, non-authorization penalties and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <b>preferred providers</b> , see <a href="http://www.healthnet.com/providersearch">www.healthnet.com/providersearch</a> or call 1-800-522-0088.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /retail order \$30 <a href="#">copay</a> /mail order	Not covered	Medical <a href="#">deductible</a> applies to Tiers 1-4. Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. <a href="#">Prior authorization</a> is required for select drugs. If <a href="#">prior authorization</a> 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 <a href="#">copay</a> /retail order \$60 <a href="#">copay</a> /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$50 <a href="#">copay</a> /retail order \$100 <a href="#">copay</a> /mail order	Not covered	
	More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthnet.com">www.healthnet.com</a>	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance</a> up to \$250 per prescription	Not covered

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

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% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some outpatient surgical procedures require <a href="#">prior authorization</a> or a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Some outpatient surgical procedures require <a href="#">prior authorization</a> .
If you need immediate medical attention	<a href="#">Emergency room care</a>	Medical, mental health & substance use disorders- Facility & professional services-20% <a href="#">coinsurance</a>	Medical, mental health & substance use disorders- Facility & professional services-20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	Medical, mental health & substance use disorders- 20% <a href="#">coinsurance</a>	Medical, mental health & substance use disorders- 20% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained in a non-emergency a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Urgent care</a>	Medical, mental health & substance use disorders- 20% <a href="#">coinsurance</a>	Medical, mental health & substance use disorders- 50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> services which meet the criteria for emergency care are payable at the <a href="#">preferred provider</a> level of coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained in a non-emergency a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> 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% <a href="#">coinsurance</a> Other than office visit-20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained for services other than office visits, a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained in a non-emergency a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .

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% <a href="#">coinsurance</a> Postnatal-20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 100 visits per calendar year, combined between <a href="#">preferred provider network</a> and <a href="#">out-of-network</a> visits ( <a href="#">rehabilitative</a> and <a href="#">habilitative home health services</a> are each limited to separate 100 visit limits each calendar year). <a href="#">Prior authorization</a> is required for some services or a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Skilled nursing center</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .
	<a href="#">Hospice services</a>	\$0 after <a href="#">deductible</a> has been met	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required for hospice facility admissions only. If <a href="#">prior authorization</a> is not obtained a \$250 penalty will apply through the <a href="#">preferred provider network</a> , a \$500 penalty will apply <a href="#">out-of-network</a> .

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
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge <a href="#">deductible</a> does not apply	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge <a href="#">deductible</a> does not apply	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance deductible</a> 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"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs-exclusion does not apply to preventive care behavioral interventions</li> </ul> |
|--|---|--|

#### 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"> <li>• Abortion-termination of pregnancy and related services are covered in full</li> <li>• Acupuncture-covered when medically necessary</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery-covered through the preferred provider network if medically necessary</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)-screenings/eye refraction for vision correction purposes</li> </ul> |
|--|---|---|

## 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](http://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](http://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](http://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](http://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](http://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](http://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**

**In this example, Peg would pay:**

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

**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**

**In this example, Joe would pay:**

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

**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**

**In this example, Mia would pay:**

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

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