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.myhealthnetca.com or call 1-800-839-2172. 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.myhealthnetca.com or you can call 1-800-839-2172 to request a copy.

### Important Questions

<p>| What is the overall deductible? | $0. | See the Common Medical Events chart below for 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, but see the chart starting on page 2 for other costs for services this plan covers. |
| What is the out-of-pocket limit for this plan? | $7,800 member / $15,600 family per calendar year. | 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 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 <a href="http://www.myhealthnetca.com">www.myhealthnetca.com</a> or call 1-800-839-2172. | 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. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-network Provider <em>(You will pay the least)</em> $30/visit</td>
<td>Out-of-Network Provider <em>(You will pay the most)</em> Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$65/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test <em>(x-ray, blood work)</em></td>
<td>Lab - $40/visit X-ray - $75/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$275/procedure</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier I drugs <em>(most generic and low cost preferred brands)</em></td>
<td>$15/retail order $30/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier II drugs <em>(non-preferred generics and preferred brands)</em></td>
<td>$55/retail order $110/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier III drugs <em>(non-preferred brands)</em></td>
<td>$80/retail order $160/mail order</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier IV drugs <em>(Specialty drugs)</em></td>
<td>20% coinsurance up to $250 per 30 day script</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee <em>(e.g., ambulatory surgery center)</em></td>
<td>$300/procedure</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$40/visit</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>In-network Provider (You will pay the least) Facility - $350/visit Physician - No charge</td>
<td>Copays not required if admitted as an inpatient.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Out-of-Network Provider (You will pay the most) Facility - $350/visit Physician - No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Facility - $250/transport</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Physician - No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In-network Provider (You will pay the least) Facility - $350/visit Physician - No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office visit - $30/visit Other than office visit - No charge</td>
<td>Prior authorization required except for office visits. Each group therapy session requires only one half of a private office visit copayment.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal - No charge Postnatal - $30/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Coverage includes abortion services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$600/day</td>
<td>Copay required up to 5 days max. Coverage includes abortion services.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$30/visit</td>
<td>Limited to 100 visits each calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$30/visit</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$300/day</td>
<td>Copay required up to 5 days max. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Limited to 1 visit per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>No charge</td>
<td>Provider selected frames; 1 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)
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
- Infertility services
- 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
- Routine eye care (Adult)

Your Rights to Continue Coverage:
Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the plan at 1-800-839-2172. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-800-839-2172, submit a grievance form through www.MyHealthNetCA.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

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.com
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 1-800-839-2172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-839-2172.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-839-2172.

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-839-2172.

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthnetca.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** $0
- **Specialist copayment** $65
- **Hospital (facility) copayment** $600
- **Other copayment** $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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60

**The total Peg would pay is** $1,560

### 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** $65
- **Hospital (facility) copayment** $600
- **Other copayment** $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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60

**The total Joe would pay is** $2,560

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

- **The plan’s overall deductible** $0
- **Specialist copayment** $65
- **Hospital (facility) copayment** $600
- **Other copayment** $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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0

**The total Mia would pay is** $1,110

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

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

**Health Net:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

**Individual & Family Plan (IFP) Members On Exchange/Covered California** 1-888-926-4988 (TTY: 711)

**Individual & Family Plan (IFP) Members Off Exchange** 1-800-839-2172 (TTY: 711)

**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)

**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Members) or Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

English

Arabic

Armenian

Chinese
免費語言服務。您可使用口譯服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線: 1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाबषया प्रास कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़ा सकते हैं। मदद के लिए, अपने आईएफपी कार्ड में दिए गए नंबर पर गाड़ी सेवा केंद्र को कॉल करें या व्यक्तिगत और फेज़िली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कॉलिसीनिया बाज़ार के लिए, आईएफपी ऑफ एक्सचेंज 1-888-926-4988 (TTY: 711) या स्वीट विज्ञेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से गुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें。

Hmong

Khmer
សេវាភាសាសោយឥតគិតថ្លៃ។ សោកអ្នកទទួលបានអ្នកបកប្បផ្ ទា ល់មាត់។ សោកអ្នកសាដា ប់សគអានឯកសារឱ្យសោកអ្នកជាភាសារបេ្ក។ េូមសៅទូរេ័ពទាសៅកាន់មជ្ឈមណ ្ឌ លទំនាក់ទំនងអតិ្ិជនតាមសលខបែលមានសៅសលើប័ណ ្ណេមាគា ល់ខលៃួនរបេ្ក។ 

Korean

Navajo

Persian (Farsi)
Wildfire Language Services

**Punjabi (Punjabi)**

ਬਿਨਾਂ ਬਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਿ ਦੁਭਾਸੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਿਰ ਸਿਦੇ ਹੋ। ਤੁਹਾਨੂ ਰ  ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸਾ ਬਵੱਚ ਪੜ੍ਹ ਿੇ ਸੁਣਾਏ ਜਾ ਸਿਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਿਾਰਡ ਤੇ ਬਦੱਤੇ ਨ ੰਿਰ ਤੇ ਗਾਹਿ ਸੰਪਰਿ ਿੇਂਦਰ ਨੂ ਰ  ਿਾਲ ਿਰੋ ਜਾਂ ਬਵਅਿਤੀਗਤ ਅਤੇ ਪਬਰਵਾਰਿ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਿਸਚੇਂਜ "ਤੇ ਿਾਲ ਿਰੋ: 1-800-839-2172 (TTY: 711)। ਿੈਲੀਫੋਰਨੀਆ ਮਾਰਬਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਿਸਚੇਂਜ ਨੂ ਰ  1-888-926-4988 (TTY: 711) ਨੋ ਸਮੈਲ ਨਿਤਲੇਮ ਵੁੱਡ 1-888-926-5133 (TTY: 711) 'ਤੇ ਿਾਲ ਿਰੋ। ਹੈਲਥ ਨ ਈ ਰਟ ਰਾਹੀਂ ਸਾਮੂਬਹਿ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਿਾਲ ਿਰੋ।
Vietnamese

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)