



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	Answers	Why This Matters:
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 ?	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, 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 ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Premiums , penalties for non-certification and healthcare 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 non-IHCP preferred providers , see www.myhealthnetca.com 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 ?	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			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-network Provider (You will pay more)	Non-IHCP 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	No charge	No charge	Not covered	None
	Specialist visit	No charge	No charge	Not covered	None
	Preventive care/screening/immunization	No charge	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhealthnetca.com/druglist	Tier I drugs (most generic and low cost preferred brands)	No charge	No charge	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Preauthorization is required for select drugs.
	Tier II drugs (non-preferred generics and preferred brands)	No charge	No charge	Not covered	
	Tier III drugs (non-preferred brands)	No charge	No charge	Not covered	
	Tier IV drugs (Specialty drugs)	No charge	No charge	Not covered	Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Preauthorization is required for select drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	No charge	None
	Urgent care	No charge	No charge	No charge	None

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

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office visit-No charge Other than office visit-No charge	Not covered	None
	Inpatient services	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
If you are pregnant	Office visits	No charge	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	No charge	Not covered	Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Limited to 100 visits per year. If preauthorization is not obtained a \$250 penalty will apply.
	Rehabilitation services	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Habilitation services	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Skilled nursing care	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Durable medical equipment	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Hospice services	No charge	No charge	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	No charge	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge	No charge	Not covered	None

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

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|-----------------------|--|---|
| • Chiropractic care | • Infertility services | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (exclusion does not apply to preventive care behavioral interventions) |
| • Hearing aids | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| • Abortion services | • Bariatric surgery (covered through participating provider network if deemed medically necessary) | • Routine eye care (Adult) (screenings/eye refraction for vision correction purposes) |
| • Acupuncture (covered when medically necessary) | | |

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 1-800-522-0088, 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. 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 1-800-839-2172.

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, kwijigo holne' 1-800-839-2172.

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	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

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

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	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

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	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

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

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	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.