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?	For participating providers $6,300 per member / $12,600 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, first 3 non-preventive visits per year combined (including primary care, specialist, other practitioner, urgent care & postnatal), laboratory tests, outpatient mental health & substance use services, rehabilitation & habilitation, hospice, pediatric dental and vision care are covered before you meet your deductible.	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?	Yes. Preferred pharmacy deductible $500 per person / $1,000 per family per calendar year. Pharmacy deductible applies to tiers 1-4. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For participating providers $8,200 per member / $16,400 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, 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 **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
		Participating 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	$65 copay/visit	Not covered	Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care & postnatal non-preventive visits are combined.
	Specialist visit	$95 copay/visit	Not covered	Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care & postnatal non-preventive visits are combined.
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	X-ray-40% coinsurance Lab-$40 copay/visit deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	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)	$18 copay/retail order $36 copay/mail order after prescription drug deductible has been met	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Preauthorization is required for select drugs. Deductible required for prescription drugs $500 per member / $1,000 per family per calendar year. Tier II and Tier III will have a coinsurance maximum of $500 per individual prescription of up to a 30-day supply or $1,500 for a 90-day supply.
	Tier II drugs (non-preferred generics and preferred brands)	40% coinsurance after prescription drug deductible has been met retail/mail order	Not covered	
	Tier III drugs (non-preferred brands)	40% coinsurance after prescription drug deductible has been met retail/mail order	Not covered	
	Tier IV drugs (Specialty drugs)	40% coinsurance after prescription drug deductible has been met retail/mail order	Not covered	Supply/order: 30 day supply from specialty Rx except where quantity limits apply. Preauthorization is required for select drugs. Deductible required for prescription drugs $500 per member / $1,000 per family per calendar year. Tier IV drugs will have a coinsurance maximum of $500 per individual prescription of up to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	Facility-40% coinsurance Physician-No charge	Facility-40% coinsurance Physician-No charge	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$65 copay/visit	$65 copay/visit	Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care & postnatal non-preventive visits are combined.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	If preauthorization is not obtained a $250 penalty will apply.
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-$65 copay/visit deductible does not apply Other than office visit- No charge	Not covered	None
	Inpatient services	40% coinsurance	Not covered	If preauthorization is not obtained a $250 penalty will apply.
If you are pregnant	Office visits	Prenatal-No charge Postnatal-$65 copay/visit	Not covered	Deductible applies after 3rd non-preventive visit. 1st 3 primary care, specialist, other practitioner, urgent care & postnatal non-preventive visits are combined. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	40% coinsurance	Not covered	Coverage includes abortion services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Limited to 100 visits per year. If preauthorization is not obtained a $250 penalty will apply.
	Rehabilitation services	$65 copay/visit deductible does not apply	Not covered	If preauthorization is not obtained a $250 penalty will apply.
	Habilitation services	$65 copay/visit deductible does not apply	Not covered	If preauthorization is not obtained a $250 penalty will apply.
	Skilled nursing care	40% coinsurance	Not covered	If preauthorization is not obtained a $250 penalty will apply.
	Durable medical equipment	40% coinsurance deductible does not apply	Not covered	If preauthorization is not obtained a $250 penalty will apply.
	Hospice services	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	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
- 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.)

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

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$65

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	$6,300
Copayments	$500
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,260**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$65

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	$1,300
Copayments	$900
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,420**

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

The plan's overall deductible	$6,300
Specialist copayment	$95
Hospital (facility) coinsurance	40%
Other copayment	$65

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	$1,700
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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