



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 \$8,550 member / \$17,100 family. Does not apply to preventive care & pediatric vision.	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 , 1 st 3 non-preventive primary care, other practitioner office visit, urgent care , outpatient mental health and substance abuse & postnatal visits combined and pediatric vision 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?	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 ?	For participating providers \$8,550 member / \$17,100 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 , 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	No charge after deductible has been met, deductible applies after 3 rd non-preventive visit	Not covered	Deductible applies after 3 rd non-preventive visit. 1 st 3 primary care, other practitioner office visit, urgent care , outpatient mental health and substance abuse & postnatal visits are combined.
	Specialist visit	No charge after deductible has been met	Not covered	None
	Preventive care/screening/immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible has been met	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible has been met	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 after 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. Before the deductible is met, you pay the difference in cost between the brand name and generic drug plus copay or coinsurance .
	Tier II drugs (non-preferred generics and preferred brands)	No charge after deductible has been met	Not covered	
	Tier III drugs (non-preferred brands)	No charge after deductible has been met	Not covered	
	Tier IV drugs (Specialty drugs)	No charge after deductible has been met	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 after deductible has been met	Not covered	None
	Physician/surgeon fees	No charge after deductible has been met	Not covered	None

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

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 immediate medical attention	Emergency room care	Facility-No charge after deductible has been met Physician-No charge	Facility-No charge after deductible has been met Physician-No charge	None
	Emergency medical transportation	No charge after deductible has been met	No charge after deductible has been met	None
	Urgent care	No charge after deductible has been met, deductible applies after 3 rd non-preventive visit	No charge after deductible has been met, deductible applies after 3 rd non-preventive visit	Deductible applies after 3 rd non-preventive visit. 1 st 3 primary care, other practitioner office visit, urgent care , outpatient mental health and substance abuse & postnatal visits are combined.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Physician/surgeon fees	No charge after deductible has been met	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-No charge after deductible has been met, deductible applies after 3 rd non-preventive visit Other than office visit- No charge after deductible has been met	Not covered	Office visit-1 st 3 primary care, other practitioner office visit, urgent care , outpatient mental health and substance abuse & postnatal visits are combined.
	Inpatient services	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
If you are pregnant	Office visits	Prenatal-No charge Postnatal- No charge after deductible has been met, deductible applies after 3 rd non-preventive visit	Not covered	Deductible applies after 3 rd non-preventive visit. 1 st 3 primary care, other practitioner office visit, urgent care , outpatient mental health and substance abuse & postnatal visits are combined.
	Childbirth/delivery professional services	No charge after deductible has been met	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge after deductible has been met	Not covered	Coverage includes abortion services.

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

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	No charge after deductible has been met	Not covered	Limited to 100 visits each calendar year. If preauthorization is not obtained a \$250 penalty will apply.
	Rehabilitation services	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Habilitation services	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Skilled nursing care	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Durable medical equipment	No charge after deductible has been met	Not covered	If preauthorization is not obtained a \$250 penalty will apply.
	Hospice services	No charge after deductible has been met	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 after deductible has been met	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge after deductible has been met	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](#).)

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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 services • 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 |
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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 services • Acupuncture (covered when medically necessary) | <ul style="list-style-type: none"> • Bariatric surgery (covered through participating provider network if deemed medically necessary) | <ul style="list-style-type: none"> • Routine eye care (Adult) (screenings/eye refraction for vision correction purposes) |
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* For more information about limitations and exceptions, see the [plan](#) or policy document at www.myhealthnetca.com

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.dmhca.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](#).

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

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	\$8,550
■ 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	\$8,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$8,550
■ 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	\$5,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$8,550
■ 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	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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