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 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 www.dol.gov/ebsa/healthreform or www.healthnet.com or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your 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?	Yes, $100 for retail brand name drugs (except for brand name PPI drugs). There are no other specific deductibles.	You must pay all 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?	Medical limit: $1,500 member / $4,500 family per calendar year. Outpatient drugs at a Network Pharmacy: $1,600/person; $2,200/family.	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, the overall family out-of-pocket limit must been met.
What is not included in the out-of-pocket limit?	The Out-of-Pocket Limit for medical does not accumulate premiums and health care this plan doesn't cover. The Out of Pocket Limit for In-Network prescription drugs does not accumulate premiums, non-covered expenses, charges in excess of benefit maximums and allowed charges and out-of-network copays and coinsurance.	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.healthnet.com/providersearch or call 1-800-522-0088. For an ARP Chemical Dependency provider, call the Assistance Recovery Program (ARP) at 1-800-562-3277.	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.

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
		In-network 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	$15/visit	Not covered	——————none——————
	Specialist visit	$15/visit	Not covered	Requires prior authorization.
	Preventive care /screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthnet.com/ca_druglist or www.optumrx.com	Generic drugs	HealthNet: Not covered OptumRx: Retail Pharmacy: $5 copay/fill. Mail Order: $10 copay/fill	HealthNet: Not Covered OptumRx: You pay the participating pharmacy copay/fill + any amount the pharmacy charges above the contract amount the participating pharmacy would have charged.	OptumRx: • Retail Pharmacy: 34 day supply. Mail Order: 90-day supply • Max Plan payment of $30 for retail PPI drugs ($90 mail order). • If you obtain a brand drug at a Retail Pharmacy when a generic drug is available, you pay the brand copay per fill + cost difference between the brand and generic drug (unless physician specifies no generic substitution). • If the cost of the drug is less than the copay, you pay just the drug cost. Some drugs are subject to step therapy, quantity limits and preauthorization. • No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate).
	Preferred brand drugs	HealthNet: Not covered OptumRx: Retail Pharmacy: $25 copay/fill. Mail Order: $50 copay/fill		
	Non-preferred brand drugs	HealthNet: Not covered OptumRx: Retail Pharmacy: $40 copay/fill. Mail Order: $80 copay/fill		
	Specialty drugs	HealthNet: No charge (for certain injectable specialty drugs provided in the doctor's office). Other specialty drugs are not covered. Optum Rx: Generic: 20% to $50 maximum copay/fill Brand: 20% to $100 copay/fill Non-Preferred: 20% to $200 maximum copay/fill	Not covered	OptumRx: available only through OptumRx Specialty Drug Program

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network 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)	No charge	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$35/visit	$35/visit	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$35/visit	$35/visit	Cost sharing waived if admitted to the hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/stay	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	HealthNet: Office- $15/visit- individual therapy session $7.50/visit- group therapy session. Other than office- No charge ARP: 10% coinsurance	HealthNet and ARP: Not covered	HealthNet: Prior authorization required except for office visits. ARP: These benefits are for the employee and spouse only. Elective hospitalization requires Preauthorization to avoid a $300 penalty.
	Inpatient services	HealthNet: No charge ARP: 10% coinsurance	HealthNet and ARP: Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	$150/stay	Not covered	Coverage includes abortion services. Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	$15/visit	Not covered	Copay starts the 31st day after the first visit. Requires prior authorization.
	Rehabilitation services	No charge	Not covered	Requires prior authorization.
	Habilitation services	Not covered	Not covered	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$150/stay	Not covered	Limited to 100 days per calendar year. Requires prior authorization.
	Durable medical equipment	No charge	Not covered	Corrective footwear is not covered. Requires prior authorization.
	Hospice services	No charge	Not covered	Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	$15/visit	Not covered	You may have additional vision benefits through a separate vision plan administered by VSP.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	You may have additional dental benefits through a separate dental plan administered by Delta Dental.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (Child) (available only through a separate benefit administered by Delta Dental up to $2,500/calendar year)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (Child)(screenings/eye refraction for vision correction purposes) and you may have additional vision benefits (adult/children) available through VSP.
- Routine foot care
- Weight loss programs (except as otherwise required under health reform)

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

- Acupuncture (covered as a specialist visit if deemed medically necessary)
- Chiropractic care – Your group has purchased a chiropractic benefit rider. When you use a practitioner in the American Specialty Health Plan network, chiropractic care is covered with a copayment of $10/visit up to 20 visits per calendar year. You may self-refer for the initial visit; subsequent visits require prior auth.
- Infertility treatment

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com

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. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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, 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

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 1-800-522-0088.

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, kwiijigo holne' 1-800-522-0088.

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

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.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	$15
Hospital (facility) copayment	$150
Other copayment	$15

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:

Cost Sharing	
Deductibles	$0
Copayments	$370
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$380

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	$15
Hospital (facility) copayment	$150
Other copayment	$15

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:

Cost Sharing	
Deductibles	$0
Copayments	$650
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$670

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$150
Other copayment	$15

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:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$100

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