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 https://www.healthcare.gov/sbc-glossary 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 charge below for your 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.
What is the out-of-pocket limit for this plan?	Medical limit: $2,000 member/$6,000 family through HMO; $2,000 member/$6,000 family through PPO per calendar year. HMO and PPO networks cross accumulate. Prescription Drugs In-Network: $2,000/individual, $4,000/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, 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?	Medical limit: Premiums, prescription drug costs and healthcare this plan doesn't cover. Prescription Drug limit: premiums, balance-billing charges, medical expenses, 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 www.healthnet.com/providersearch or call 1-800-522-0088.	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. HMO network only. 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 HMO Provider (You will pay the least)	In-network PPO Provider (You will pay more)	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	$40/visit	$60/visit	Not covered	——————none——————
	Specialist visit	$40/visit	$60/visit	Not covered	Requires prior authorization.
	Preventive care/screening/ immunization	No charge for covered services	No charge for covered services	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	$100/procedure	Not covered	Not covered	Requires prior authorization.

* 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 HMO Provider (You will pay the least)	In-network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs (Formulary generic drugs)	**Retail:** $10 copayment/script. **Mail order:** $20 copayment/script		Not covered (limited exceptions for emergency prescriptions)	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Limited to a 30-day supply at retail and a 90-day supply for mail-order. • Mail Order is required for maintenance medications after the third fill at a retail pharmacy. After the 3rd refill at retail, you will be charged 2 copayments/fill. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate). • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Preferred brand drugs (Formulary brand)	**Retail:** $20 copayment/script. **Mail order:** $40 copayment/script			
	Non-preferred brand drugs (Non-formulary generic or Non-formulary brand drugs)	If preauthorization is obtained, paid as a formulary drug			
	Specialty drugs	Same copayments as retail formulary generic and retail formulary brand drugs copayments.		Not covered.	• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit). • Specialty drugs must be purchased through the Optum Specialty Pharmacy after the first fill at retail. Call (855) 798-5682 for information. • Limited to a 30-day supply.

* 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 HMO Provider (You will pay the least)	In-network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$100/visit	$100/visit	$100/visit	Copay waived if admitted as inpatient.
	Emergency medical transportation	$100/transport	$100/transport	$100/transport	——————none——————
	Urgent care	$40/visit	$40/visit	$40/visit	Copay waived if admitted as inpatient.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Severe-Office-$15/visit-individual therapy session Other than office-No charge Non-severe & Substance abuse-Office-$30/visit individual therapy session Other than office-No charge	Office-$60/visit Other than office-No charge	Not covered	Group therapy sessions require ½ of the office visit copayment. Requires prior authorization except for office visits.
	Inpatient services	20% coinsurance	Not covered	Not covered	Requires prior authorization.
If you are pregnant	Office visits	$40/visit	Not covered	Not covered	Cost sharing does not apply for preventive care.
	Childbirth/delivery professional services	No charge	Not covered	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	30% coinsurance	Not covered	Not covered	Coverage includes abortion services.

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com EXM/NO/YMY/CB

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-network HMO Provider (You will pay the least)	In-network PPO Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$40/visit	Not covered	Not covered	Limited to 100 visits per calendar year. Copayment begins with the first visit. Requires prior authorization.
	Rehabilitation services	$40/visit	$60/visit	Not covered	PPO limited to therapy in an office only. Requires prior
	Habilitation services	Not covered	Not covered	Not covered	——————none——————
	Skilled nursing care	Days 1-10: No charge Days 11-100: $25/day	Not covered	Not covered	Limited to 100 days per calendar year. Requires prior
	Durable medical equipment	No charge	Not covered	Not covered	Corrective footwear is not covered. Requires prior
	Hospice services	No charge	Not covered	Not covered	Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	$40/visit	$60/visit	Not covered	Additional coverage available under separate vision plan available through the Fund, if elected.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	If you elect dental coverage, it will be available under a separate dental plan.

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.)

- Cosmetic surgery
- Dental care (Adult or Child) (available under separate dental plan)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing Routine foot care
- Weight loss programs
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* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com

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 through the HMO tier if deemed medically necessary) • Bariatric surgery	• 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 30 visits per calendar year. You may self-refer for the initial visit; subsequent visits require prior authorization.	• Infertility treatment • Routine eye care (Adult) (additional coverage available under separate vision

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 or the 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，请请打这个号码 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	$40
Hospital (facility) coinsurance	30%
Other copayment	$40

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	$100
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,010

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	$40
Hospital (facility) coinsurance	30%
Other copayment	$40

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	$910
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$910

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other copayment	$40

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

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