



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 chart 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 out-of-pocket limit: \$1,500 member/\$3,000 family through Salud per calendar year; \$1,500 member/\$3,000 family through SIMNSA per calendar year. Salud and SIMNSA Networks cross accumulate. Prescription drug out-of-pocket limit: (applicable to <u>prescription drugs</u> from <u>network pharmacies</u> , except certain <u>specialty drugs</u>): \$750 individual / \$1,500/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 ?	Medical out-of-pocket limit: Premiums , prescription drug costs, balance billing charges, health care this plan doesn't cover, and services indicated in the chart starting on page 3. Prescription drug out-of-pocket limit (in-network): premiums , amounts (other than copayment) paid for brand drug when generic is available, balance-billing charges, and health care this plan doesn't cover. Copayments for certain specialty drugs that are not essential health benefits (though eligible for reimbursement by the manufacturer at no cost to you) do not apply towards satisfying your out-of-pocket limit and will not be reimbursed at 100% once the out-of-pocket limit is reached.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters
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. Requires written preauthorization .	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 SIMNSA Network (Mexico members)	What You Will Pay Health Net Salud Network (California members)	What You Will Pay SIMNSA Network (Self-referral for California members)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay /visit	\$5 copay /visit	\$5 copay /visit	None
	Specialist visit	\$5 copay /visit	\$5 copay /visit	\$5 copay /visit	Requires preauthorization .
	Preventive care/screening /immunization	No charge for covered services	No charge for covered services	No charge for covered services	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	No charge	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	No charge	Requires preauthorization .

Common Medical Event	Services You May Need	What You Will Pay SIMNSA Network (Mexico members)	What You Will Pay Health Net Salud Network (California members)	What You Will Pay SIMNSA Network (Self-referral for California members)	Limitations, Exceptions & Other Important Information
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.expresscripts.com or call 1-800-451-6245</p>	Preventive drugs	Not covered	No charge	Not covered	<p>You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. Each retail prescription limited to a maximum 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order. For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision. Except in case of urgent medical need, <u>specialty drugs</u> must be filled through the Accreddo pharmacy.</p> <p>Some drugs require <u>preauthorization</u>.</p> <p>If you use a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable <u>copay</u>. No charge for ACA-required <u>preventive care</u> drugs if purchased at a <u>network</u> pharmacy with a prescription.</p> <p>For information on drugs not covered by the <u>plan</u>, call 1 800-451-6245, visit www.express-scripts.com, or download the Express Scripts app.</p> <p>Certain <u>specialty drugs</u> have substantially higher <u>copays</u> than shown. If you are on one of these <u>specialty drugs</u> and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher <u>copays</u>. However, if your <u>specialty drug</u> is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full <u>copay</u>. The <u>specialty drugs</u> on the SaveOn SP Drug list, and the <u>copays</u> for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a <u>specialty drug</u> that is part of the SaveOn SP program. Please see "Important Questions" on page 1 for more information regarding the <u>prescription drug out-of-pocket limit</u>.</p>
	Generic drugs	Not covered	\$3 <u>copay</u> / prescription (retail or mail order)	Not covered	
	Brand name drugs		\$6 <u>copay</u> / prescription (retail); \$5 <u>copay</u> prescription (mail order)		
	Specialty drugs		\$3 <u>copay</u> for generic (retail or mail order) \$6 <u>copay</u> / brand prescription (retail) \$5 <u>copay</u> / brand prescription (mail order)		

* 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 SIMNSA Network (Mexico members)	What You Will Pay Health Net Salud Network (California members)	What You Will Pay SIMNSA Network (Self-referral for California members)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Hospital & ASC No charge	No charge	Requires preauthorization .
	Physician/surgeon fees	No charge	No charge	No charge	None
If you need immediate medical attention	Emergency room care	\$10 copay /visit	\$150 copay /visit	\$10 copay /visit	Copay waived if admitted as inpatient.
	Emergency medical transportation	No charge	\$50 copay /transport	No charge	Air ambulance is not covered through SIMNSA Network.
	Urgent care	\$10 copay /visit	\$5 copay /visit	\$10 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	Requires preauthorization .
	Physician/surgeon fees	No charge	No charge	No charge	None

Common Medical Event	Services You May Need	What You Will Pay SIMNSA Network (Mexico members)	What You Will Pay Health Net Salud Network (California members)	What You Will Pay SIMNSA Network (Self-referral for California members)	Limitations, Exceptions & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$5/visit Other than office-No charge	Office-\$5 copay /visit-individual therapy session \$5 copay /visit-group therapy session Other than office-No charge	Office-\$5/visit Other than office-No charge	Behavioral health services through Salud Network are administered by Managed Health Network (MHN). Requires preauthorization except for office visits.
	Inpatient services	No charge	No charge	No charge	Behavioral health services through Salud Network are administered by Managed Health Network (MHN). Requires preauthorization .
If you are pregnant	Office visits	No charge	Prenatal & Postnatal-No charge	No charge	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No charge	No charge	No charge	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	No charge	No charge	Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	Not covered	No charge	Not covered	Requires preauthorization .
	Rehabilitation services	\$5 copay /visit	\$5 copay /visit	\$5 copay /visit	Requires preauthorization .
	Habilitation services	\$5 copay /visit	\$5 copay /visit	\$5 copay /visit	Requires preauthorization .
	Skilled nursing care	No charge	No charge	No charge	SIMNSA is limited to 100 combined days per calendar year. Requires preauthorization .
	Durable medical equipment	No charge	20% coinsurance	No charge	Corrective footwear is not covered. Requires preauthorization .
	Hospice services	No charge	No charge	No charge	Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires preauthorization .

Common Medical Event	Services You May Need	What You Will Pay SIMNSA Network (Mexico members)	What You Will Pay Health Net Salud Network (California members)	What You Will Pay SIMNSA Network (Self-referral for California members)	Limitations, Exceptions & Other Important Information
If your child needs dental or eye care	Children's eye exam	\$5 copay /visit	\$5 copay /visit	\$5 copay /visit	Covered through Health Net (not covered through Vision Service Plan)
	Children's glasses	Not covered	Health Net: Not covered VSP: No charge for frames under \$120 allowance (80% of costs above \$120). No charge for most standard lenses.	Not covered	For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months. Charges apply for lens add-ons and premium progressive lenses. VSP provides limited out-of-network benefits.
	Children's dental check-up	Not covered	Not covered	Not covered	You may have other dental coverage not described here.

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](#).)

<ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic surgery 	<ul style="list-style-type: none"> • Hearing aids • 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.)

<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • Dental care (Adult) (available through separate standalone plan) • Infertility treatment-SIMNSA is limited to services that diagnose infertility only 	<ul style="list-style-type: none"> • Routine eye care (Adult) – limited benefits for frames/lenses available through VSP plan
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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 on how 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 1-800-522-0088.

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

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
<ul style="list-style-type: none"> The plan's overall deductible \$0 Specialist copayment \$5 Hospital (facility) copayment \$0 Other copayment \$5 		<ul style="list-style-type: none"> The plan's overall deductible \$0 Specialist copayment \$5 Hospital (facility) copayment \$0 Other copayment \$5 		<ul style="list-style-type: none"> The plan's overall deductible \$0 Specialist copayment \$5 Hospital (facility) copayment \$0 Other copayment \$5 	
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$0	Copayments	\$200	Copayments	\$300
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$50
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$70	The total Joe would pay is	\$220	The total Mia would pay is	\$350

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