**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall deductible? | HMO/PPO: N/A. OON: $500 member/ $1,500 family per calendar year. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.

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.

Is there an out-of-pocket limit on my expenses? | Yes. HMO: $1,500 member/ $3,000 two-party/ $4,500 family, PPO: $2,500 member/ $5,000 two-party/ $7,500 family, OON: $4,000 member/ $8,000 two-party/ $12,000 family per calendar year. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit? | Premiums, balance-billed charges and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.

Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers? | Yes. For a list of **preferred providers**, see [www.healthnet.com](http://www.healthnet.com) or call 1-800-522-0088. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I 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 the plan’s permission before you see the **specialist**.

Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call the number on your Health Net ID card (current members) or 1-800-522-0088 or visit us at [www.healthnet.com](http://www.healthnet.com). If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [http://cciio.cms.gov](http://cciio.cms.gov) or call 1-800-522-0088 or the number on your Health Net ID card to request a copy.
Health Net of CA: SELECT POS ABL

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Covered Members | Plan Type: POS

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost if You Use an In-network HMO Provider</th>
<th>Your Cost if You Use an In-network PPO Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>HMO – if your medical group authorizes medically necessary acupuncture or chiropractic care, it is covered as a specialist visit (see above). Chiropractic care is limited to 15 combined visits per calendar year. Requires prior authorization.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Not covered</td>
<td>Acupuncture – Not covered</td>
<td>Acupuncture – Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Chiropractor – 30% co-ins</td>
<td>Chiropractor – 30% co-ins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>Until age 18-30% co-ins Age 18 and older-Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires referral.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage:
### What this Plan Covers & What it Costs

#### Coverage Period: 02/01/2014-01/31/2015

**Coverage for:** All Covered Members  
**Plan Type:** POS

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<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
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</thead>
</table>
| If you need drugs to treat your illness or condition | Preferred generic drugs | $10/retail order  
$20/mail order | $10/retail order  
$20/mail order | $10/retail order | Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. If you buy a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name and generic drug plus copay or co-ins for the generic. Out of Network pharmacy provider covered outside of California only.  
Supply/order: 30 day supply from specialty pharmacy except where quantity limits apply. Prior authorization is required for select drugs. Out of network provider may require upfront payment from you. |
|                     | Preferred brand drugs | $15/retail order  
$30/mail order | $15/retail order  
$30/mail order | $15/retail order | |
|                     | Non-preferred brand or generic drugs | $35/retail order  
$70/mail order | $35/retail order  
$70/mail order | $35/retail order | |
|                     | Specialty drugs | No charge | 20% co-ins | 30% co-ins | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% co-ins | 30% co-ins | Requires prior authorization. |
|                     | Physician/surgeon fees | No charge | 20% co-ins | 30% co-ins | May require prior authorization. |
| If you need immediate medical attention | Emergency room services | $75/visit | $100/visit | 30% co-ins | Copay/co-ins not required if you are admitted as a hospital inpatient. |
|                     | Emergency medical transportation | No charge | 20% co-ins | 30% co-ins | Air ambulance – max of $750 each incident through PPO/OON combined. Requires prior authorization. Ground ambulance – max distance of 75 miles an incident through PPO/OON combined. |
|                     | Urgent care | $75/visit | $100/visit | 30% co-ins | Copay/co-ins not required if you are admitted as a hospital inpatient. |
| If you have a | Facility fee (e.g., hospital room) | $150/stay | 20% co-ins | 30% co-ins | Requires prior authorization. |
## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

### Coverage Period: 02/01/2014-01/31/2015

**Plan Type:** POS

**Coverage for:** All Covered Members

### What this Plan Covers & What it Costs

#### Coverage for:

- **All Covered Members**

#### Plan Type:

- **POS**

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#### Common Medical Event

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</tr>
</thead>
<tbody>
<tr>
<td><strong>hospital stay</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>————none———</td>
</tr>
<tr>
<td><strong>Mental/Behavioral health outpatient services</strong></td>
<td>$15/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Requires prior authorization except office visits.</td>
</tr>
<tr>
<td><strong>Mental/Behavioral health inpatient services</strong></td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>Substance use disorder outpatient services</strong></td>
<td>$15/visit for individual therapy session $7.50/visit for group session</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Require prior authorization except office visits.</td>
</tr>
<tr>
<td><strong>Substance use disorder inpatient services</strong></td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care</td>
<td>$20/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>$150/stay</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>$20/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Copay starts 31st calendar day after the first visit through HMO/PPO. Limited to 100 combined visits per calendar year through PPO/OON. Requires prior authorization.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$20/visit</td>
<td>$30/visit</td>
<td>30% co-ins</td>
<td>Limited to 60 combined visits per calendar year through PPO/OON. Requires prior authorization.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$150/stay</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Limited to 100 days per calendar year through HMO. Limited to 60 combined days per cal year through PPO/OON. Requires prior auth.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>50% co-ins</td>
<td>Not covered</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge</td>
<td>20% co-ins</td>
<td>30% co-ins</td>
<td>Requires prior authorization.</td>
</tr>
<tr>
<td><strong>If your child needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>$20/visit</td>
<td>Not covered</td>
<td>Not covered</td>
<td>————none———</td>
</tr>
</tbody>
</table>
Summary of Benefits and Coverage:

What this Plan Covers & What it Costs

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Coverage for: All Covered Members, Plan Type: POS

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</thead>
<tbody>
<tr>
<td>dental or eye care</td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>none</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Child & Adult)
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Infertility treatment
- Routine eye care (Adult)

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- 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 $5/visit up to 40 visits per calendar year. You may self-refer for the initial visit; subsequent visits require prior authorization.
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-522-0088. 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:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can 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. 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 Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 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.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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