



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/policy/sbg_platinum_90_ppo_250_15_alt_2022 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 ?	For preferred providers \$250 per person / \$500 per family; for out-of-network providers \$1,000 per person / \$2,000 per family per calendar year.	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 , physician office visits, x-ray & lab tests, prescription drugs , urgent care , outpatient mental health & substance use disorder office visits, prenatal & postnatal office visits, outpatient rehabilitation & habilitation , hospice , chiropractic services, acupuncture services and pediatric dental and vision care 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.
What is the out-of-pocket limit for this plan ?	For preferred providers \$3,800 per person / \$7,600 per family; for out-of-network providers \$9,000 per person / \$18,000 per 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 ?	Premiums , balance billing charges, expenses paid for chiropractic services, drug discount, coupon or copay cards for prescription drugs, penalties for non-certification 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 ?	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 Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	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	\$15 copay /visit deductible does not apply	50% coinsurance	None
	Specialist visit	\$30 copay /visit deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No charge	50% coinsurance	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)	Lab-\$30 copay /visit deductible does not apply X-ray-\$30 copay /visit deductible does not apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
If you need drugs to treat your illness or condition	Preferred generic drugs (Tier 1)	\$10 copay /retail order deductible does not apply \$20 copay /mail order deductible does not apply	Not covered	Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. Preauthorization is required for select drugs. If preauthorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.
More information about prescription drug coverage is available at https://www.healthnet.com/content/healthnet/en_us/find-a-plan/employer-group-drug-lists.html	Non-preferred generic and preferred brand drugs (Tier 2)	\$35 copay /retail order deductible does not apply \$70 copay /mail order deductible does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$60 copay /retail order deductible does not apply \$120 copay /mail order deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	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 https://www.healthnet.com/content/healthnet/en_us/find-a-plan/employer-group-drug-lists.html</p>	Specialty drugs (Tier 4)	10% coinsurance up to \$250 per 30 day prescription deductible does not apply	Not covered	Supply/order: 30 day supply from specialty pharmacy except where quantity limits apply. Preauthorization is required for select drugs. If preauthorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Some outpatient surgical procedures require certification or a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Some outpatient surgical procedures require certification.
If you need immediate medical attention	Emergency room care	Facility-10% coinsurance Professional services-10% coinsurance	Facility-10% coinsurance Professional services-10% coinsurance	Cost sharing waived if admitted as inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	Medical-\$30 copay /visit deductible does not apply Mental health & substance use disorders-\$15 copay /visit deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	If certification is not obtained in a non-emergency a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Physician/surgeon fees	10% coinsurance	50% coinsurance	Certification is required for a hospital stay and some services received while admitted to the hospital.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-\$15 copay deductible does not apply Other than office visit- 10% coinsurance	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	If certification is not obtained in a non-emergency a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
If you are pregnant	Office visits	Prenatal-No charge Postnatal-\$15 copay deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 100 visits per calendar year, combined between preferred provider network and out-of-network visits (rehabilitative and habilitative home health services are each limited to separate 100 visit limits each calendar year). Certification is required for some services or a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Rehabilitation services	\$15 copay /visit deductible does not apply	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Habilitation services	\$15 copay /visit deductible does not apply	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Skilled nursing center	10% coinsurance	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Durable medical equipment	10% coinsurance	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
	Hospice services	No charge	50% coinsurance	If certification is not obtained a \$250 penalty will apply through the preferred provider network , a \$500 penalty will apply out-of-network .
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	Not covered	Provider selected frames; 1 per calendar year.
	Children's dental check-up	No charge	10% coinsurance deductible does not apply	Limited to 1 check-up every 6 months.

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"> • Cosmetic surgery • Dental care (Adult) • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment • 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 (exclusion does not apply to preventive care behavioral interventions) |
|---|---|--|

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

- Abortion services
- Acupuncture (covered when medically necessary)
- Bariatric surgery (covered through the preferred provider network if medically necessary)
- Chiropractic care (limited to 12 visits per calendar year)
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

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 1-888-926-4988, submit a grievance form through www.myhealthnetca.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 Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or at 1-800-927-HELP (4357), 1-800 482-4833 TDD or at www.insurance.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at the contact information provided above.

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.

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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)		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)	
▪ The plan's overall deductible	\$250	▪ The plan's overall deductible	\$250	▪ The plan's overall deductible	\$250
▪ Specialist copayment	\$30	▪ Specialist copayment	\$30	▪ Specialist copayment	\$30
▪ Hospital (facility) coinsurance	10%	▪ Hospital (facility) coinsurance	10%	▪ Hospital (facility) coinsurance	10%
▪ Other coinsurance	10%	▪ Other coinsurance	10%	▪ Other coinsurance	10%
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>)		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>)		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>)	
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	\$250	Deductibles	\$250	Deductibles	\$250
Copayments	\$400	Copayments	\$900	Copayments	\$200
Coinsurance	\$1,100	Coinsurance	\$50	Coinsurance	\$200
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$1,810	The total Joe would pay is	\$1,220	The total Mia would pay is	\$650

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