



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnet.com or by calling 1-800-522-0088.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
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. \$4,000 per member / \$8,000 per family each 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 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 <i>specific</i> 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 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. 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 4. See your policy or plan document for additional information about excluded services .

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- **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 in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/visit	Not covered	—————none—————
	Specialist visit	\$40/visit	Not covered	Requires prior authorization.
	Other practitioner office visit	Acupuncture- \$20/visit Chiropractic- Not covered	Not covered	Acupuncture services administered by American Specialty Health.
	Preventive care/screening/immunization	No charge	Not covered	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - \$20/visit X-ray - \$40/visit	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	\$150/procedure	Not covered	Requires prior authorization.

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Health Net of CA: Community Care HMO Platinum \$20/\$0 9KU Coverage Period: 1/1/14-12/31/14

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: All Covered Members | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthnet.com	Preferred generic drugs	\$5/retail order \$10/mail order all generics except specialty generics	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. Third and subsequent refills of maintenance drugs must be filled by mail order or a CVS retail pharmacy. Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30 days supply filled by specialty pharmacy.
	Preferred brand drugs	\$15/retail order \$30/mail order	Not covered	
	Non-preferred brand and generic drugs	\$25/retail order \$50/mail order non-preferred brands only	Not covered	
	Specialty drugs	10% co-ins	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250/procedure	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	—————none—————
If you need immediate medical attention	Emergency room services	\$150/visit	\$150/visit	Copay not required if admitted as an inpatient.
	Emergency medical transportation	\$150/transport	\$150/transport	—————none—————
	Urgent care	\$40/visit	\$40/visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250/day	Not covered	5 days copay max per admission. Requires prior authorization.
	Physician/surgeon fee	No charge	Not covered	—————none—————

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20/visit- individual therapy session \$10/visit- group therapy session	Not covered	Prior authorization required except for office visits.
	Mental/Behavioral health inpatient services	\$250/day	Not covered	5 days copay max per admission. Requires prior authorization.
	Substance use disorder outpatient services	\$20/visit- individual therapy session \$10/visit- group therapy session	Not covered	Prior authorization required except for office visits.
	Substance use disorder inpatient services	\$250/day	Not covered	5 days copay max per admission. Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	Prenatal- No charge Postnatal- \$20/visit	Not covered	—————none—————
	Delivery and all inpatient services	\$250/day	Not covered	5 days copay max per admission. Coverage includes abortion services. Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	\$20/visit	Not covered	Limited to 100 visits each calendar year. Requires prior authorization.
	Rehabilitation services	\$20/visit	Not covered	Requires prior authorization.
	Habilitation services	\$20/visit	Not covered	Requires prior authorization.
	Skilled nursing care	\$150/day	Not covered	5 days copay max per admission. Requires prior authorization.
	Durable medical equipment	10% co-ins	Not covered	Includes coverage for up to 2 medically necessary contact lenses per eye in any 12 month period. Requires prior authorization.
	Hospice service	No charge	Not covered	Requires prior authorization.
If your child needs	Eye exam	No charge	Not covered	Limited to 1 visit per year.

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dental or eye care	Glasses	No charge	Not covered	Provider selected frames; 1 per calendar year.
	Dental check-up	No charge	Not covered	_____none_____

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 <u>excluded services</u> .)			
<ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (child & adult) 	<ul style="list-style-type: none"> • Hearing aids • Infertility services • 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 	

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.)		
<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Bariatric surgery 	<ul style="list-style-type: none"> • Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep health this coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit Fraud
- The insurer stops offering services in the State
- You move outside the coverage area

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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.

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 page.*—————

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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.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$6,540
- Patient pays: \$1,000

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$1,000

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$4,580
- Patient pays: \$820

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$700
Coinsurance	\$20
Limits or exclusions	\$100
Total	\$820

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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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