Health Net of CA: CVS Caremark Health Net POS 80

Coverage Period: 6/01/2014 – 5/31/2015

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

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/cvscaremark or by calling 888-893-1598

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 through HMO (Tier 1). $1,500 per member / $3,000 per family per plan year for PPO. $2,000 per member / $4,000 per family per plan year for OON.	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: $2,500 person, $5,000 for two-party contract, $7,500 family. PPO/OON combined: $5,000 person, $10,000 for two-party contract, $12,500 family per plan 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, some deductibles, copays and coinsurance; 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/cvscaremark or call 1-888-853-1598.	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**.

- **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.

		Your Cost if You Use an			
Common Medical Event	**Services You May Need**	**In-network HMO Provider (Tier 1)**	**In-network PPO Provider (Tier 2)**	**Out-of-network Provider (Tier 3)**	**Limitations & Exceptions**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	$55/visit	50% co-ins	————————None————————
	Specialist visit	$45/visit	$55/visit	50% co-ins	HMO: requires prior authorization.
	Other practitioner office visit	Not covered	40% co-ins (chiropractor) Acupuncture – not covered	50% co-ins (chiropractor) Acupuncture – not covered	HMO: chiropractic care & acupuncture covered as a specialist visit if medical group authorizes. PPO/OON: Chiropractor visits - Combined 15 visits/plan year.
	Preventive care/screening/ immunization	No charge	No charge	Not covered	————————None————————
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins	40% co-ins	50% co-ins	HMO: Requires referral.
	Imaging (CT/PET scans, MRIs)	20% co-ins	40% co-ins	50% co-ins	Requires prior authorization.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network HMO Provider (Tier 1)	In-network PPO Provider (Tier 2)	Out-of-network Provider (Tier 3)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs 30 day supply 90 day supply *Standard & Value Formulary Options*	$7.50 per prescription $9.99 per prescription	$7.50 per prescription $9.99 per prescription	Not covered	Preventive medications for specific conditions, as outlined under the Affordable Care Act, are covered at no charge to you. There is **no charge** for in-network generic and preferred brand oral contraceptives. Infertility medications have a lifetime maximum of $10,000. Erectile Dysfunction medications limited to 6 pills per month. Maintenance medications must be filled as a 90 day supply at a CVS/pharmacy or through CVS Caremark Mail Order Pharmacy after two initial 30 day supplies are filled. Under the *Standard Formulary Option*, if you get a brand drug when a generic is available, you will pay the generic co-pay or coinsurance plus the difference between the discounted cost of the generic and brand drug. Non-preferred brand drugs are not available under the *Value Based Formulary Option*.
	Preferred brand drugs 30 day supply 90 day supply *Standard & Value Formulary Options*	20% co-ins $41.50 per prescription	20% co-ins $41.50 per prescription	Not covered	
	Non-preferred brand drugs 30 day supply 90 day supply *Standard Formulary Option Only*	35% co-ins $91 per prescription	35% co-ins $91 per prescription	Not covered	
	Specialty drugs – 30 day supply	$75 per prescription	$75 per prescription	Not covered	Available through CVS Caremark Specialty Pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	40% co-ins	50% co-ins	OON: outpatient surgery at an ambulatory surgical center limited to a maximum amount of $350/day. Requires prior authorization.
	Physician/surgeon fees	20% co-ins	40% co-ins	50% co-ins	May require prior authorization.
If you need immediate medical attention	Emergency room services	20% co-ins	40% co-ins	50% co-ins	Co-ins waived for ER services if admitted as a hospital inpatient.
	Emergency medical transportation	No charge	40% co-ins	50% co-ins	Air ambulance: maximum of $750 each incident for PPO/OON combined.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network HMO Provider (Tier 1)	In-network PPO Provider (Tier 2)	Out-of-network Provider (Tier 3)	Limitations & Exceptions
	Urgent care	$45/visit	40% co-ins	50% co-ins	Copay/co-ins waived if admitted as a hospital inpatient.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment + 20% co-ins	40% co-ins	50% co-ins	May require prior authorization
	Physician/surgeon fee	20% co-ins	40% co-ins	50% co-ins	May require prior authorization
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30/visit	$55/visit	50% co-ins	Requires prior authorization except for office visits. LifeScope For You EAP provides unlimited phone consultations, up to 6 free in-person outpatient visits per member/ issue/ year (no prior authorization). Contact EAP at 800-789-8990 or by email: Help@4healthcare.com. Additional resources available at www.LifeScope4You.com
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	$500 copayment + 20% co-ins	40% co-ins	50% co-ins	Requires prior authorization.
	Substance use disorder outpatient services	$30/visit-individual session $15/visit-group session	$55/visit	50% co-ins	Requires prior authorization except for office visits.
	Substance use disorder inpatient services	$500 copayment + 20% co-ins	40% co-ins	50% co-ins	Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	No charge	40% co-ins	50% co-ins	HMO: $30 copayment for initial office visit to diagnose pregnancy.
	Delivery and all inpatient services	$500 copayment + 20% co-ins	40% co-ins	50% co-ins	May require prior authorization.
If you need help recovering or have	Home health care	$30/visit	40% co-in	50% co-ins	HMO: Limited to 100 visits per plan year. PPO/OON: combined limit of 50 visits per

Common Medical Event	Services You May Need	Your Cost if You Use an In-network HMO Provider (Tier 1)	In-network PPO Provider (Tier 2)	Out-of-network Provider (Tier 3)	Limitations & Exceptions
other special health needs					plan year. Requires prior authorization.
	Rehabilitation services	$45/visit	40% co-ins	50% co-ins	PPO/OON: Combined limit of 60 visits per plan year for physical and occupational therapy, and a combined limit of 40 visits per plan year for speech therapy.
	Habilitation services	Not covered	Not covered	Not covered	————None————
	Skilled nursing care	20% co-ins	40% coins	50% coins	HMO: Limited to 100 visits per plan year. PPO/OON combined limit of 50 visits. Requires prior authorization.
	Durable medical equipment	20% co-ins	40% co-ins	50% co-ins	May require prior authorization
	Hospice service	No charge	40% co-ins	50% co-ins	Requires prior authorization.
If your child needs dental or eye care	Eye exam	$30/visit	Not covered	Not covered	Preventive vision screenings covered at no charge through HMO & PPO. Requires prior authorization
	Glasses	Not covered	Not covered	Not covered	————None————
	Dental check-up	Not covered	Not covered	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 excluded services.)

- Cosmetic surgery
- Dental care (Child & Adult)
- Formulary exclusions
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Over-the-counter medications & equipment unless otherwise specified
- 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.)

- Acupuncture (medically necessary covered under Tier 1 only)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatments- lifetime maximum benefit of $10,000 for infertility medications
- 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 1-888-893-1598. 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 1-888-893-1598, submit a grievance form through www.healthnet.com/cvscaremark, 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 1-888-893-1598.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-893-1598.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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** $ 6,140
- **Patient pays** $ 1,400

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	$500
Co-ins	$700
Limits or exclusions	$200
Total	**$1,400**

Coverage examples based on tier 1. Individual member coverage.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $ 4,530
- **Patient pays** $ 870

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$500
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Co-ins	$70
Limits or exclusions	$200
Total	**$870**

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 **co-insurance** 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 **co-insurance**. 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.