ambetter. FROM Health Net

Ambetter Balanced Care 9 (2017)

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

Coverage Period: Beginning on or after 01/01/2017

Coverage for: All Covered Members | **Plan Type:** HMO

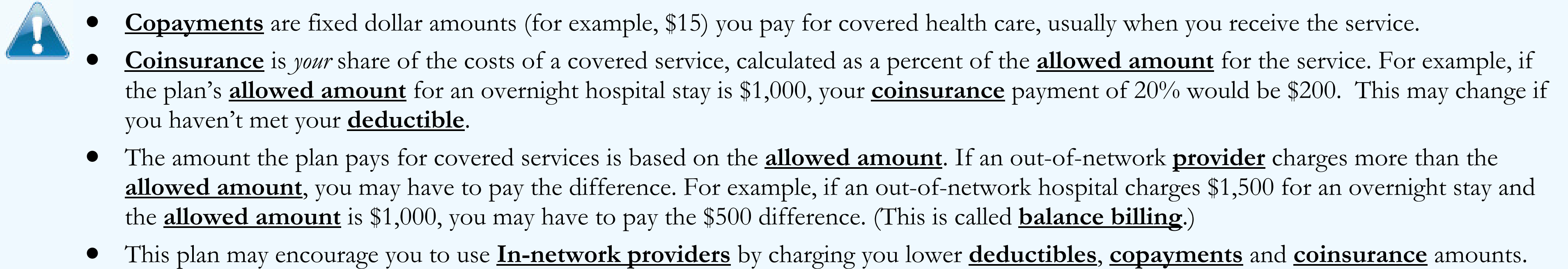
1-888-926-5057

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.ambetterhealthnet.com or by calling 1-888-926-5057.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$4,200 member / $8,400 family per calendar year. Does not apply to preventive care.	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. $7,150 member / $14,300 family per calendar year. Deductible included in out-of-pocket limit.	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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.ambetterhealthnet.com or call 1-888-926-5057.	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?	No.	You can see the **specialist** you choose without permission from this plan.
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 Ambetter from Health Net ID card (current members) or 1-888-926-5057 or visit us at www.ambetterhealthnet.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 or call 1-888-926-5057 or the number on your Ambetter from Health Net ID card to request a copy.

Note: The coverage period shown above for this plan may be different than the effective date of your particular policy.



- **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 **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	$30/visit deductible waived	Not covered	——————none——————
	Specialist visit	$50/visit deductible waived	Not covered	——————none——————
	Other practitioner office visit	Other practitioner-$30/visit deductible waived; Chiropractic-$50/visit deductible waived; Acupuncture-Not covered	Not covered	Chiropractic-Limited to 20 visits per calendar year. Acupuncture-Not covered
	Preventive care/screening/immunization	No charge deductible waived	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Office Xray-$50/visit deductible waived; Office Lab-$20/visit deductible waived; Hospital-20% coinsurance deductible applies	Not covered	——————none——————

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
	Imaging (CT/PET scans, MRIs)	Office-$250/procedure deductible waived; Hospital- 20% coinsurance deductible applies	Not covered	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ambetterhealthnet.com	Generic drugs	$20/retail order deductible waived $60/mail order deductible waived	Not covered	Supply/order: 30 day (retail); 30-90 day (mail order), If you select a brand name drug that has a generic equivalent, your cost will be higher, May require prior authorization.
	Preferred brand drugs or preferred insulin	$40/retail order deductible applies; $120/mail order deductible applies	Not covered	
	Non-preferred brand drugs	$70/retail order deductible applies; $210/mail order deductible applies	Not covered	
	Anti-cancer drugs	20% coinsurance/order deductible applies	Not covered	
	Specialty drugs	50% coinsurance/order deductible applies	Not covered	Supply/order: 30 day supply filled by a specialty pharmacy. May require prior authorization
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance deductible applies	Not covered	Requires prior authorization.
	Physician/surgeon fees	20% coinsurance deductible applies	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$400/visit deductible waived	$400/visit deductible waived	Copay waived if admitted from emergency room.
	Emergency medical transportation	No charge deductible waived	No charge deductible waived	——————none——————
	Urgent care	$50/visit deductible waived	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance deductible applies	Not covered	Requires prior authorization.
	Physician/surgeon fee	20% coinsurance deductible applies	Not covered	——————none——————

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	Office- $30/visit deductible waived; Other than office- 20% coinsurance deductible waived	Not covered	Office-May require prior authorization. Other than office- Requires prior authorization.
	Mental/Behavioral health inpatient services	20% coinsurance deductible applies	Not covered	Requires prior authorization.
	Substance abuse disorder outpatient services	Office- $30/visit deductible waived; Other than office- 20% coinsurance deductible waived	Not covered	Requires prior authorization.
	Substance abuse disorder inpatient services	20% coinsurance deductible applies	Not covered	Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	Prenatal PCP-$30/visit deductible waived; Specialist-$50/visit deductible waived; Postnatal-No charge deductible waived	Not covered	Prenatal-Copay waived after initial visit.
	Delivery and all inpatient services	20% coinsurance deductible applies	Not covered	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	No charge deductible waived	Not covered	Limited to part-time and intermittent nursing care. Requires prior authorization.
	Rehabilitation services	Inpatient- 20% coinsurance deductible applies; Outpatient-$50/visit deductible waived	Not covered	Outpatient-Limited to 60 visits per calendar year (all therapies combined). Requires prior authorization.
	Habilitation services	Inpatient- 20% coinsurance deductible applies; Outpatient-$50/visit deductible waived	Not covered	Outpatient-Limited to 60 visits per calendar year (all therapies combined). Requires prior authorization.
	Skilled nursing care	20% coinsurance deductible applies	Not covered	Limited to 100 days per calendar year. Requires prior authorization.

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
	Durable medical equipment	20% coinsurance deductible applies	Not covered	Requires prior authorization.
	Hospice service	Inpatient- 20% coinsurance deductible applies; In Home-No charge deductible waived	Not covered	Requires prior authorization.
If your child needs dental or eye care	Eye exam	No charge deductible waived	Not covered	Eye exams are limited to 1 visit per year.
	Glasses	No charge deductible waived	Not covered	Glasses are limited to 1 pair per year. Ambetter from Health Net vision benefits are provided through Eyemed.
	Dental check-up	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.)**

- Abortion services (except in cases of rape, incest or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing except when medically necessary
- Weight loss program

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.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Routine foot care (Covered only in connection with the treatment of diabetes)

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

For more information on your rights to continue coverage, contact the plan at 1-888-926-5057. 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: Ambetter from Health Net Customer Contact Center at 1-888-926-5057, submit a grievance form through www.ambetterhealthnet.com, or file your complaint in writing to, Commercial Appeals and Grievances Department, Attn: Appeals & Grievances Manager, Ambetter from Health Net, P.O. Box 277610, Sacramento, CA 95827. You may also call the Consumer Services Division of the Arizona Department of Insurance at 602-364-2499 or 1-800-325-2548 (outside the Metro Phoenix area).

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 (Espanol): Para obtener asistencia en Espanol, llame al 1-800-223-7691.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-223-7691.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-223-7691.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-223-7691.

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

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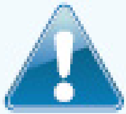
About these Coverage Examples:

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** $2,520
- **Patient pays** $5,020

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	$4,200
Copays	$20
Coinsurance	$600
Limits or exclusions	$200
Total	**$5,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $780
- **Patient pays** $4,620

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	$4,200
Copays	$300
Coinsurance	$40
Limits or exclusions	$80
Total	**$4,620**

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.