



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/2021/eoc/pco/epo/bronze60iex](http://www.healthnet.com/2021/eoc/pco/epo/bronze60iex) or call 1-888-926-4988. 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.myhealthnetca.com](http://www.myhealthnetca.com) or you can call 1-888-926-4988 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">preferred providers</a> \$6,300 per person / \$12,600 per family per calendar year.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , laboratory tests, <a href="#">rehabilitation</a> and <a href="#">habilitation</a> services, <a href="#">hospice</a> ; first 3 non-preventive visits per year combined (including non-preventive primary care, <a href="#">specialist</a> , other practitioner office visits & medical <a href="#">urgent care</a> visits); mental health, behavioral health or substance abuse <a href="#">urgent care</a> visits and outpatient office visits; pediatric vision and pediatric dental care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. Preferred pharmacy <a href="#">deductible</a> \$500 per person / \$1,000 per family per calendar year. Pharmacy <a href="#">deductible</a> applies to tiers 1-4. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">preferred providers</a> \$8,200 per person / \$16,400 per family per calendar year.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, penalties for non-certification and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of <b>preferred providers</b> , see <a href="http://www.myhealthnetca.com/findadoctor">www.myhealthnetca.com/findadoctor</a> or call 1-888-926-4988.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply for 1 <sup>st</sup> 3 visits	Not covered	<a href="#">Preferred provider deductible</a> applies after first 3 non-preventive visits combined (including non-preventive primary care, <a href="#">specialist</a> , other practitioner office visits & medical <a href="#">urgent care</a> visits).
	<a href="#">Specialist</a> visit	\$95 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply for 1 <sup>st</sup> 3 visits	Not covered	<a href="#">Preferred provider deductible</a> applies after first 3 non-preventive visits combined (including non-preventive primary care, <a href="#">specialist</a> , other practitioner office visits & medical <a href="#">urgent care</a> visits).
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab-\$40 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply X-ray-40% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	Not covered	If certification is not obtained a \$250 penalty will apply.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myhealthnetca.com/druglist">www.myhealthnetca.com/druglist</a>	Generic drugs (Tier 1)	\$18 <a href="#">copay</a> /retail order \$36 <a href="#">copay</a> /mail order after pharmacy <a href="#">deductible</a> has been met	Not covered	Supply/order: up to 30 day (retail); 31-90 day (mail), except where quantity limits apply. <a href="#">Preauthorization</a> is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care. Preferred pharmacy <a href="#">deductible</a> applies \$500 per member / \$1,000 per family. Tier 2 and Tier 3 drugs will have a <a href="#">coinsurance</a> maximum of \$500 per individual prescription for up to a 30-day supply or \$1,500 for a 90-day supply.
	Preferred brand drugs (Tier 2)	40% <a href="#">coinsurance</a> up to a maximum of \$500 per 30 day script after pharmacy <a href="#">deductible</a> has been met retail/mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	40% <a href="#">coinsurance</a> up to a maximum of \$500 per 30 day script after pharmacy <a href="#">deductible</a> has been met retail/mail order	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.myhealthnetca.com/druglist">prescription drug coverage</a> is available at <a href="http://www.myhealthnetca.com/druglist">www.myhealthnetca.com/druglist</a>	<a href="#">Specialty drugs</a> (Tier 4)	40% <a href="#">coinsurance</a> up to a maximum of \$500 per 30 day script after pharmacy <a href="#">deductible</a> has been met	Not covered	Supply/order: 30 day supply from specialty Rx except where quantity limits apply. <a href="#">Preauthorization</a> is required for select drugs or you will be subject to a penalty of 50% of the average wholesale price, except for emergency care. Preferred pharmacy <a href="#">deductible</a> applies \$500 per member / \$1,000 per family. Tier 4 drugs will have a <a href="#">coinsurance</a> maximum of \$500 per individual prescription for up to a 30-day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	Not covered	Some outpatient surgical procedures require certification or a \$250 penalty will apply.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Some outpatient surgical procedures require certification.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Facility fee- 40% <a href="#">coinsurance</a> Professional services- No charge	Facility fee- 40% <a href="#">coinsurance</a> Professional services- No charge	Cost sharing waived if admitted into the hospital.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	Medical-\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply for 1 <sup>st</sup> 3 visits Mental health, behavioral health or substance abuse-\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	50% coinsurance	<a href="#">Preferred provider deductible</a> applies after first 3 non-preventive visits combined (including non-preventive primary care, <a href="#">specialist</a> , other practitioner office visits & medical <a href="#">urgent care</a> visits).
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	Not covered	If certification is not obtained in a non-emergency a \$250 penalty will apply.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not covered	Certification is required for a hospital stay and some services received while admitted to the hospital.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visit-\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply Other than office visit-40% <a href="#">coinsurance</a> up to \$65 <a href="#">copay</a> /visit	Not covered	<a href="#">Preferred provider deductible</a> applies after first 3 non-preventive visits combined (including non-preventive primary care, <a href="#">specialist</a> , other practitioner office visits & medical <a href="#">urgent care</a> visits). Certification is not required for outpatient services for mental health and substance use disorder diagnoses except for <a href="#">reconstructive surgery</a> . If certification is required but not obtained a \$250 penalty will apply.
	Inpatient services	40% <a href="#">coinsurance</a>	Not covered	If certification is not obtained in a non-emergency a \$250 penalty will apply.
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	Not covered	Coverage includes abortion services.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	Not covered	Limited to 100 visits per calendar year ( <a href="#">rehabilitative</a> and <a href="#">habilitative home health services</a> are each limited to separate 100 visit limits each calendar year). Certification is required for some services or a \$250 penalty will apply.
	<a href="#">Rehabilitation services</a>	\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	Not covered	If certification is not obtained a \$250 penalty will apply.
	<a href="#">Habilitation services</a>	\$65 <a href="#">copay</a> /visit <a href="#">deductible</a> does not apply	Not covered	If certification is not obtained a \$250 penalty will apply.
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a>	Not covered	If certification is not obtained a \$250 penalty will apply.
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	Not covered	If certification is not obtained a \$250 penalty will apply.
	<a href="#">Hospice services</a>	No charge	Not covered	If certification is not obtained a \$250 penalty will apply.
<b>If your child needs dental or eye care</b>	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	Not covered	Limited to 1 check-up every 6 months.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myhealthnetca.com](http://www.myhealthnetca.com)

## 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**.)

- |                       |  |   |
|-----------------------|--|---|
| • Chiropractic care   | • Infertility services                               | • Private-duty nursing  |
| • Cosmetic surgery    | • Long-term care                                     | • Routine foot care   |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (exclusion does not apply to preventive care behavioral interventions) |
| • Hearing aids        |  |   |

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

- |  |   |   |
|--|---|---|
| • Abortion services                              | • Bariatric surgery (covered through the preferred provider network if medically necessary) | • Routine eye care (Adult) (screenings/eye refraction for vision correction purposes) |
| • Acupuncture (covered when medically necessary) |   |   |

**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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>
- California Department of Insurance – 300 Capitol Mall Suite 1600 Sacramento CA 95814. Call toll free: (800) 927-4357 or visit <http://insurance.ca.gov/consumers>.
- Office of Personnel Management Multi State Plan Program: <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer/>.

For more information on your rights to continue coverage, contact the plan at 1-888-926-4988. 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](http://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](http://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](http://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](http://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 1-888-926-4988.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-4988.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-4988.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-926-4988.

*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)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,300
■ <a href="#">Specialist copayment</a>	\$95
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$6,300
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$1,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,260</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,300
■ <a href="#">Specialist copayment</a>	\$95
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$1,200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,300
■ <a href="#">Specialist copayment</a>	\$95
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>

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