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/uc or call 1-800-539-4072. 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 www.dol.gov/ebsa/healthreform or www.healthnet.com/uc or you can call 1-800-539-4072 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
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?	$1,000 member / $3,000 family each calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.
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.
Will you pay less if you use a network provider?	Yes. For a list of **preferred providers**, see www.healthnet.com/uc or call 1-800-539-4072.	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?	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 a referral before you see the specialist.

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
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit CVS Minute Clinic – Preventive visit - no charge Non-preventive visit - $20/visit	Not covered	——————none——————
	Specialist visit	$20/visit	Not covered	Requires prior authorization.
	Preventive care/screening/ immunization	No charge	Not covered	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)	No charge	Not covered	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	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.healthnet.com/uc	Generic drugs	$5/retail order $10/mail order	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. May use select UC or CVS pharmacies to obtain up to a 90 day supply maintenance medications. If you buy a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name and generic drug plus copay or coinsurance for the generic.
	Preferred brand drugs	$25/retail order $50/mail order	Not covered	
	Non-preferred brand drugs	$40/retail order $80/mail order	Not covered	
	Specialty drugs	Self injectables- $20/order Refer to the recommended drug list for other drugs considered specialty	Not covered	Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30 day supply filled by specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/procedure	Not covered	Requires prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$75/visit	$75/visit	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$20/visit	$20/visit	Cost sharing waived if admitted to the hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/stay	Not covered	Requires prior authorization.
	Physician/surgeon fees	No charge	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Visits 1-3 $0 copay Visits 4+ $20 copay per visit	Covered in emergencies only, at in-network level	Non-routine services require pre-authorization. Copay waived for Intensive outpatient and Partial Hospitalization. Due to Federal Mental Health Parity, psychological testing, outpatient electroconvulsive therapy, extended length therapy sessions, biofeedback and applied behavioral analysis (ABA) will be offered at no copay. Benefits provided by Managed Health Network (MHN). Call 1-888-935-5966.
	Inpatient services	$250 copay per admission	Covered in emergencies only, at in-network level	Benefits provided by Managed Health Network (MHN). Call 1-888-935-5966.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	$250/stay	Not covered	Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires prior authorization.
	Rehabilitation services	$20/visit	Not covered	Requires prior authorization.
	Habilitation services	Not covered	Not covered	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	Not covered	Limited to 100 days per calendar year. Requires prior authorization.
	Durable medical equipment	No charge	Not covered	Requires prior authorization.
	Hospice services	No charge	Not covered	Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	$20/visit	Not covered	No charge if exam takes place during preventive periodic health evaluation.
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	Not covered	Not covered	——————none——————

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.)

- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture– Your group has purchased an acupuncture benefit rider. When you use a practitioner in the American Specialty Health Plan network, acupuncture is covered with a copayment of $20/visit up to 24 visits per calendar year combined with Chiropractic. You may self-refer for the initial visit; subsequent visits require prior authorization.
- Bariatric surgery
- Chiropractic care– Your group has purchased a chiropractic benefit rider. When you use a practitioner in the American Specialty Health Plan network, chiropractic care is covered with a copayment of $20/visit up to 24 visits per calendar year combined with Acupuncture. You may self-refer for the initial visit; subsequent visits require prior authorization.
- Hearing aids (limited to 2 devices every 36 months with a $2,000 benefit maximum)
- Infertility services
- Routine eye care (Adult)

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 1-800-522-0088, 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. 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 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 plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-539-4072.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-539-4072.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-539-4072.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-539-4072.

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

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 plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other copayment	$20

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other copayment	$20

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other copayment	$20

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

- No confirmed plan changes at this time 4/24/19

The **plan** would be responsible for the other costs of these EXAMPLE covered services.