



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/calpers or call 1-888-926-4921. 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.healthcare.gov/sbc-glossary or www.healthnet.com/calpers or you can call 1-888-926-4921 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 ?	There is no deductible .	There is no deductible .
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 ?	Medical: Individual \$1,500 / Family \$3,000. Pharmacy: Individual \$6,650 / Family \$13,300 / Mail order \$1,000.	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 , the overall family out-of-pocket limit must be met. OptumRx serves as CalPERS' pharmacy benefit manager.
What is not included in the out-of-pocket limit ?	Premiums , copayments for supplemental benefits 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/calpers or call 1-888-926-4921.	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
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit	\$15/visit	\$15/visit	-----none-----
	Specialist visit	\$15/visit	\$15/visit	\$15/visit	Requires prior authorization.
	Preventive care/screening/immunization	No charge	No charge	No charge	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	No charge	No charge	Requires referral.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	No charge	Requires prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com/calpers	Generic drugs	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	\$5/30 day supply \$10/90 day supply	\$5 for drugs dispensed through SIMNSA/retail order Not covered/ mail order	Health Net Salud Network- After second fill you will pay the appropriate mail service copay for maintenance medication. 90 day supplies allowed at a contracted OptumRx pharmacy or mail order.
	Preferred brand drugs		\$20/30 day supply \$40/90 day supply		
	Non-preferred brand drugs		\$50/30 day supply \$100/90 day supply		
	Specialty drugs	Not applicable	Specialty follows tier structure above	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge	Requires prior authorization.
	Physician/surgeon fees	No charge	No charge	No charge	-----none-----

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com/calpers

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you need immediate medical attention	Emergency room care	\$15/visit	\$50/visit	\$15/visit	Cost share waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	No charge	-----none-----
	Urgent care	\$15/visit	\$15/visit	\$15/visit	Cost share waived if admitted as an inpatient.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	Requires prior authorization.
	Physician/surgeon fees	No charge	No charge	No charge	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$15/visit Other than office- No charge	Office- \$15/visit- individual therapy session \$7.50/visit- group therapy session Other than office- No charge	Office-\$15/visit Other than office- No charge	Prior authorization required except for office visits.
	Inpatient services	No charge	No charge	No charge	Requires prior authorization.
If you are pregnant	Office visits	No charge	No charge	No charge	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	No charge	No charge	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	No charge	No charge	Coverage includes abortion services. Requires prior authorization.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SIMNSA Network (Mexico members)	Health Net Salud Network (California members)	SIMNSA Network (Self-referral for California members)	
If you need help recovering or have other special health needs	Home health care	Not covered	No charge	Not covered	Requires prior authorization.
	Rehabilitation services	\$5/visit	\$15/visit	\$5/visit	Requires prior authorization.
	Habilitation services	\$5/visit	\$15/visit	\$5/visit	Requires prior authorization. Covered when medically necessary.
	Skilled nursing care	No charge	No charge	No charge	Limited to 100 days per calendar year. Requires prior authorization.
	Durable medical equipment	No charge	No charge	No charge	Requires prior authorization.
	Hospice services	No charge	No charge	No charge	Hospice care is covered in Mexico, but only when services are provided in an acute hospital setting. Requires prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	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 .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Child & Adult) • Glasses 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Out-of-network services 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com/calpers

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

- Acupuncture– \$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.
- Bariatric surgery
- Chiropractic care – \$15 per visit, 20 visits per calendar year (combined) through American Specialty Health Plan.
- Hearing aids (\$1,000 max per member every 36 months)
- 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 1-888-926-4921, submit a grievance form through www.healthnet.com/calpers, 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 1-888-926-4921.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-4921.

Chinese (中文): 如果需要中文的帮助, 拨打电话1-888-926-4921.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-926-4921.

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

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com/calpers

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](#) \$15
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$15

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$110

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](#) \$15
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$15

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$660

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$15

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$200

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