

 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 <https://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 charge 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 \$7,200/Family \$14,400/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 healthcare 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 preauthorization .	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 In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay /visit	Not covered	None
	Specialist visit	\$15 copay /visit	Not covered	Requires preauthorization .
	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 preauthorization .
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.healthnet.com/calpers.	Generic drugs	\$5 copay /30 day supply \$10 copay /90 day supply	100% out of pocket	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 copay /30 day supply \$40 copay /90 day supply	100% out of pocket	
	Non-preferred brand drugs	\$50 copay /30 day supply \$100 copay /90 day supply	100% out of pocket	
	Specialty drugs	Specialty follows the tier structure above	100% out of pocket	Certain Specialty Medications are available only through the OptumRx Specialty Pharmacy and are limited up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Requires preauthorization .
	Physician/surgeon fees	No charge	Not covered	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 In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	\$50 copay /visit	\$50 copay /visit	Copay waived if admitted as inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	\$15 copay /visit	\$15 copay /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Requires preauthorization .
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office-\$15 copay /visit-individual therapy session \$7.50 copay /visit-group therapy session Other than office-No charge	Not covered	Administered by Managed Health Network (MHN).
	Inpatient services	No charge	Not covered	Administered by Managed Health Network (MHN). Requires preauthorization .
If you are pregnant	Office visits	Prenatal-No charge Postnatal-No charge	Not covered	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	No charge	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	No charge	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 preauthorization .
	Rehabilitation services	\$15 copay /visit	Not covered	Requires preauthorization .
	Habilitation services	\$15 copay /visit	Not covered	Requires preauthorization . Covered when medically necessary.
	Skilled nursing center	No charge	Not covered	Limited to 100 days per calendar year. Requires preauthorization .

* 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 In-network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Durable medical equipment	No charge	Not covered	Requires preauthorization .
	Hospice services	No charge	Not covered	Requires preauthorization .
If your child needs dental or eye care	Children's eye exam	PCP-No charge Specialist-No charge	Not covered	None
	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](#).)

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

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| <ul style="list-style-type: none"> • Acupuncture-\$15 per visit, 20 visits per calendar year (combined with chiropractic care) through American Specialty Health Plan. • Bariatric surgery | <ul style="list-style-type: none"> • Chiropractic care-\$15 per visit, 20 visits per calendar year (combined with acupuncture) through American Specialty Health Plan. • Hearing aids (\$1,000 max per member every 36 months) | <ul style="list-style-type: none"> • Infertility treatment • Routine eye care (Adult) |
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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.

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

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 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhc.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

[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 1-888-926-4921.

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, 请拨打这个号码 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.

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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 [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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$520

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	\$2,800
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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.