



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/cardinalcare or call 1-800-250-5226. 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/cardinalcare or you can call 1-800-250-5226 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Preferred Provider : \$300 per member / Out-of-Network : \$500 per member per plan year. Preferred Provider and Out-of-Network deductibles cross accumulate. Three family members must satisfy their individual deductible to satisfy the family deductible .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care , physician office visits, prescription drugs ; mental health & substance use disorder outpatient services & urgent care visits; pediatric dental and vision care are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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?	Preferred Provider : \$6,000 per member, \$12,000 per family / Out-of-Network : \$8,000 per member, \$24,000 per family per plan year. Preferred Provider and Out-of-Network out-of-pocket limits cross accumulate.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance billing charges, penalties for non-certification 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/cardinalcare or call 1-800-250-5226.	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?	No.	You can see the specialist you choose without a referral .



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 Preferred PPO 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	\$35 copay /visit deductible does not apply	40% coinsurance	None
	Specialist visit	\$35 copay /visit deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No charge deductible does not apply	40% coinsurance	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)	20% coinsurance	40% coinsurance	Preventive lab and x-ray covered at 100%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	If certification is not obtained a \$50 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.healthnet.com/cardinalcare	Generic drugs	\$20 copay /retail order \$40 copay /mail order deductible does not apply	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail) and up to 90 day supply for maintenance drugs (one copayment will apply for each 30 day supply) except where quantity limits apply. Preauthorization is required for select drugs. If preauthorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care. 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.
	Preferred brand drugs	\$40 copay /retail order \$80 copay /mail order deductible does not apply	Not covered	
	Non-preferred brand drugs	\$40 copay /retail order \$80 copay /mail order deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay Preferred PPO Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<p>If you need drugs to treat your illness or condition.</p> <p>More information about prescription drug coverage is available at www.healthnet.com/cardinalcare</p>	Specialty drugs	\$50 copay /retail order deductible does not apply	Not covered	Supply/order up to a 30 day supply from a specialty pharmacy except where quantity limits apply. Preauthorization is required for select drugs. If preauthorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	If certification is not obtained a \$50 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	40% coinsurance	Out-of-network services which meet the criteria for emergency care are payable at the preferred PPO provider level of coverage.
	Urgent care	Medical-20% coinsurance Mental health & substance use disorders-No charge deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	If certification is not obtained a \$500 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Preferred PPO 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 mental health, behavioral health, or substance abuse services	Outpatient services	Office-No charge deductible does not apply Other than office-No charge deductible does not apply	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Non-emergency services require certification. If certification is not obtained a \$500 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .
If you are pregnant	Office visits	Prenatal-No charge deductible does not apply Postnatal-20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, occupational, and speech therapy require certification or a \$50 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing center	20% coinsurance	40% coinsurance	If certification is not obtained a \$500 penalty will apply through out-of-network providers . There is no certification penalty through the preferred PPO provider network.
	Durable medical equipment	20% coinsurance	40% coinsurance	If certification is not obtained a \$50 penalty will apply through out-of-network providers . There is no certification penalty through preferred PPO providers .

Common Medical Event	Services You May Need	What You Will Pay Preferred PPO 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	Hospice services	20% coinsurance	40% coinsurance	Inpatient hospice services require certification or a \$500 penalty will apply through out-of-network . There is no certification penalty through preferred PPO providers .
If your child needs dental or eye care	Children's eye exam	No charge deductible does not apply	Not covered	Through age 18. Limited to 1 visit per year.
	Children's glasses	No charge deductible does not apply	Not covered	Through age 18. Provider selected frames; 1 per plan year.
	Children's dental check-up	No charge deductible does not apply	10% coinsurance deductible does not apply	Limited to 1 check-up every 6 months.

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 (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs (exclusion does not apply to preventive care behavioral interventions)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care-adjustments, spinal manipulation and therapy are not covered 	<ul style="list-style-type: none"> • 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 1-800-250-5226, submit a grievance form through www.healthnet.com/cardinalcare, 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 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. 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 1-800-250-5226.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-250-5226.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-250-5226.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-250-5226.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$300
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$2,500

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$2,870
-----------------------------------	----------------

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,000
Coinsurance	\$100

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,420
-----------------------------------	----------------

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$400

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$800
-----------------------------------	--------------

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