**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 or call 1-800-522-0088. 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 or you can call 1-800-522-0088 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 limit: $1,500 member/$3,000 family through Salud; ***Prescription drug out-of-pocket limit:*** *(applicable to prescription drugs from network pharmacies, except certain specialty drugs)*: **$750** individual / **$1,500**/family | 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, prescription drug costs and health care this plan doesn't cover. ***Prescription drug out-of-pocket limit:*** premiums, amounts (other than copayment) paid for brand drug when generic is available, balance-billing charges and health care this plan doesn't cover. Copayments for certain specialty drugs that are not essential health benefits (though eligible for reimbursement by the manufacturer at no cost to you) do not apply towards satisfying your out-of-pocket limit and will not be reimbursed at 100% once the out-of- pocket limit is reached. | 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/providersearch or call 1-800-522-0088. | 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 SIMNSA Network (Mexico members) | What You Will Pay Health Net Salud Network (California members) | What You Will Pay SIMNSA Network (Self-referral for California | 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 | $5 copay/visit | $5 copay/visit | $5 copay/visit | None |
| | Specialist visit | $5 copay/visit | $5 copay/visit | $5 copay/visit | Requires prior authorization. |
| | Preventive care/screening/ immunization | No charge for covered services | No charge for covered services | No charge for covered services | 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.**<br><br>**More information about prescription drug coverage is available at www.express-scripts.com or call 1-800-451-6245** | Generic drugs | Not covered | $3 copay / prescription (retail or mail order) | Not covered | You must use a pharmacy in Express Scripts' Prime Network (within the United States) to fill your prescription or no coverage. Each retail prescription limited to a maximum 30-day supply. For maintenance medications, up to a 90-day supply is available using mail order. For maintenance drugs, you must decide whether to use mail order or a retail pharmacy. Two retail fills are allowed before you must notify Express Scripts of your decision. Except in case of urgent medical need specialty medications must be filled through the Accredo pharmacy.<br>Some drugs require preauthorization. |
| | Brand name drugs | Not covered | $ 6 copay / prescription (retail)<br>$5 copay / prescription (mail order) | Not covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay SIMNSA Network (Mexico members) | What You Will Pay Health Net Salud Network (California members) | What You Will Pay SIMNSA Network (Self-referral for California | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|---|
| | Specialty drugs | Not covered | $3 copay for generic (retail or mail order)<br><br>$ 6 copay / brand prescription (retail)<br><br>$5 copay / brand prescription (mail order) | Not covered | If you use a brand name drug when a generic is available, you will pay the difference in price between the brand name and the generic drug, plus the applicable copay. No charge for ACA-required preventive care drugs if purchased at a network pharmacy with a prescription from a physician.<br><br>For information on drugs not covered by the plan, call 1-800-451-6245, visit www.express-scripts.com, or download the Express Scripts app.<br>Certain specialty drugs have substantially higher copays than shown. If you are on one of these specialty drugs and you participate in the SaveOn SP program through Express Scripts, you will not have to pay the higher copays. However, if your specialty drug is on the SaveOn SP Drug list and you do not participate in the SaveOn SP program, you will be responsible for the full copay. The specialty drugs on the SaveOn SP Drug list, and the copays for those drugs, are subject to change. You will receive notification from SaveOn SP if you are on a specialty drug that is part of the SaveOn SP program. Please see "Important Questions" on page 1 for more information regarding the prescription drug out-of-pocket limit. |

| Common Medical Event | Services You May Need | What You Will Pay SIMNSA Network (Mexico members) | What You Will Pay Health Net Salud Network (California members) | What You Will Pay SIMNSA Network (Self-referral for California | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | Hospital-No charge<br>ASC-No charge | No charge | Requires prior authorization. |
| | Physician/surgeon fees | No charge | No charge | No charge | None |
| **If you need immediate medical attention** | Emergency room care | $10 copay/visit | $150 copay/visit | $10 copay/visit | Copay waived if admitted into the hospital. |
| | Emergency medical transportation | No charge | $50 copay/transport | No charge | Air ambulance is not covered through SIMNSA. |
| | Urgent care | Medical-$10 copay/visit<br>Mental health & substance use disorders-$5 copay/visit | Medical-$5 copay/visit<br>Mental health & substance use disorders-$5 copay/visit | Medical-$10 copay/visit<br>Mental health & substance use disorders-$5 copay/visit | None |
| **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-$5 copay/visit<br>Other than office-No charge | Office-individual therapy session-$5 copay/visit<br>group therapy session-$5 copay/visit<br>Other than office-No charge | Office-$5 copay/visit<br>Other than office-No charge | Requires prior authorization except for office visits. |
| | Inpatient services | No charge | No charge | No charge | Requires prior authorization. |
| **If you are pregnant** | Office visits | No charge | Prenatal-No charge<br>Postnatal-No charge | No charge | Cost sharing does not apply for preventive services. |

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

| Common Medical Event | Services You May Need | What You Will Pay SIMNSA Network (Mexico members) | What You Will Pay Health Net Salud Network (California members) | What You Will Pay SIMNSA Network (Self-referral for California | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|---|
| | Childbirth/delivery professional services | No charge | No charge | No charge | None |
| | Childbirth/delivery facility services | No charge | No charge | No charge | None |
| **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 copay/visit | $5 copay/visit | $5 copay/visit | Requires prior authorization. |
| | Habilitation services | $5 copay/visit | $5 copay/visit | $5 copay/visit | |
| | Skilled nursing center | No charge | No charge | No charge | SIMNSA is limited to 100 days combined per calendar year. Requires prior authorization. |
| | Durable medical equipment | No charge | 20% coinsurance | No charge | Corrective footwear is not covered. 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 | $5 copay/visit | PCP-$5 copay/visit Specialist-$5 copay/visit | $5 copay/visit | None |
| | Children's glasses | ***Health Net***: Not covered ***VSP (at in-network providers):*** 80% of costs above $120 allowance for basic frames. No charge for most standard lenses. | ***Health Net***: Not covered ***VSP (at in-network providers):*** 80% of costs above $120 allowance for basic frames. No charge for most standard lenses. | ***Health Net***: Not covered ***VSP (at in-network providers):*** 80% of costs above $120 allowance for basic frames. No charge for most standard lenses. | For vision coverage through Vision Service Plan (VSP), call 1-855-866-0942 for benefit information. Lenses and frames limited to once every 24 months. Charges apply for lens add-ons and premium progressive lenses. VSP has limited benefits out-of-network. |
| | Children's dental check-up | Not covered | Not covered | Not covered | You may have other dental coverage not described here. |

## 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.)**

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

| | | |
|---|---|---|
| • Acupuncture<br>• Chiropractic care<br>• Cosmetic surgery | • Hearing aids<br>• Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Private-duty nursing<br>• Routine foot care<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Abortion-termination of pregnancy and related services are covered in full; for services rendered in Mexico, terminations of pregnancy are covered to the extent permitted by Mexican law. | • Bariatric surgery<br>• Children's glasses (limited benefit for frames/lenses available through VSP)<br>• Dental care (available through separate standalone plan) | • Infertility treatment-SIMNSA services are limited to the diagnosis of infertility only.<br>• Routine eye care (Adult) (limited benefit for frames/lenses available through VSP) |

### 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 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhc.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care 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 1-800-522-0088.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-0088.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-522-0088.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-522-0088.

*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 | $5 |
| Hospital (facility) copayment | $0 |
| Other copayment | $5 |

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **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 | $5 |
| Hospital (facility) copayment | $0 |
| Other copayment | $5 |

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $50 |
| Coinsurance | $250 |
| *What isn't covered* | |
| Limits or exclusions | $3,500 |
| **The total Joe would pay is** | **$3,750** |

### Mia's Simple Fracture

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $5 |
| Hospital (facility) copayment | $0 |
| Other copayment | $5 |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$360** |

Coverage examples do not include the value of the non-Kaiser benefits provided by other carriers. Contact the Plan Administrator with any questions.

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