Health Net Life Ins. Co.: OOS PPO PLAN B 9CQ

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** All Covered Persons | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnet.com or by calling 1-800-847-3991.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 for each member (PPO & OON). Three family members each must satisfy their individual deductible to satisfy the family deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Services that require copay are not subject to the deductible.
Are there other deductibles for specific services?	Yes. Infertility services have a lifetime deductible of $500.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. PPO: $3,000 for each member/OON: $9,000 each member.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Prescription drug costs, premiums, balance-billed charges, expenses used to meet the deductible, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.healthnet.com or call 1-800-522-0088.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call the number on your Health Net ID card (current members) or 1-800-847-3991 or visit us at www.healthnet.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call 1-800-847-3991 or the number on your Health Net ID card to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network PPO Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20	40% co-ins	——————none——————
	Specialist visit	$20	40% co-ins	——————none——————
	Other practitioner office visit	Chiropractic & Acupuncture-$20	Chiropractic & Acupuncture-40% co-ins	Combined limit of 20 visits and limited to a max of $25 per visit (PPO/OON combined).
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins	40% co-ins	——————none——————
	Imaging (CT/PET scans, MRIs)	20% co-ins	40% co-ins	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Preferred generic drugs	$10/retail order $20/mail order	$10 + 50% AWP/retail order	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. If you buy a brand name drug that has a generic equivalent, you pay the difference in cost between the brand name and generic plus copay or coinsurance.
	Preferred brand drugs	$20/retail order $40/mail order	$20 + 50% AWP/retail order	
	Non-preferred brand or generic drugs	$35/retail order $70/mail order	$35 + 50% AWP /retail order	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network PPO Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
www.healthnet.com	Specialty drugs	$20	40% co-ins	Supply/order up to a 30 day supply specialty pharmacy except where quantity limits apply. Prior authorization required for select drugs. Out of network provider may require up front payment from you.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	40% co-ins	Requires prior authorization.
	Physician/surgeon fees	20% co-ins	40% co-ins	——————none——————
If you need immediate medical attention	Emergency room services	20% co-ins	40% co-ins	$100 deductible waived if admitted as hospital inpatient.
	Emergency medical transportation	20% co-ins	40% co-ins	Air ambulance requires prior authorization.
	Urgent care	20% co-ins	40% co-ins	$100 deductible waived if admitted as hospital inpatient.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	40% co-ins	Through OON, maximum allowable per day is $600. Requires prior authorization.
	Physician/surgeon fee	20% co-ins	40% co-ins	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20	40% co-ins	Requires prior authorization except for office visits.
	Mental/Behavioral health inpatient services	20% co-ins	40% co-ins	Through OON, max amount allowable is $600 each day. Requires prior authorization.
	Substance use disorder outpatient services	$20	40% co-ins	Requires prior authorization except for office visits.
	Substance use disorder inpatient services	20% co-ins	40% co-ins	Through OON, max amount allowable is $600 each day. Requires prior authorization.
If you are pregnant	Prenatal and postnatal care	$20	40% co-ins	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network PPO Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% co-ins	50% co-ins	Requires prior authorization.
If you need help recovering or have other special health needs	Home health care	20% co-ins	40% co-ins	Each day of care is limited to a max payable of $110. Requires prior authorization.
	Rehabilitation services	20% co-ins	40% co-ins	Combined limit of 20 visits (PPO/OON). Requires prior authorization.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% co-ins	40% co-ins	Through OON, max amount allowable is $250 each day. Requires prior authorization.
	Durable medical equipment	20% co-ins	40% co-ins	Combined limit of $2,000 (PPO/OON) max per calendar year.
	Hospice service	20% co-ins	40% co-ins	Requires prior authorization.
If your child needs dental or eye care	Eye exam	$20	Not covered	Children through age 16.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility services (Lifetime max of $2,000)

Your Rights to Continue Coverage:

If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-522-0088. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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. If you have a grievance against Health Net, you can also contact the California Department of Insurance, at 1-800-927-HELP (4357) or via the Consumers portal of www.insurance.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.

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 5,510
- **Patient pays** $ 2,030

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,360
Limits or exclusions	$150
Total	**$2,030**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $ 3,670
- **Patient pays** $ 1,730

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$490
Copays	$1,120
Coinsurance	$0
Limits or exclusions	$120
Total	**$1,730**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the number on your Health Net ID card (current members) or 1-800-847-3991 or visit us at www.healthnet.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call 1-800-847-3991 or the number on your Health Net ID card to request a copy.