

## Ambetter from Health Net : Ambetter Balanced Care 9 (2018)

Coverage for: Individual/Family | Plan Type: HMO



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 <https://ambetterhealthnet.com/2018-brochures.html>, or call 1-800-289-2818 (1-800-977-6757 TTY: 711). 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 call 1-800-289-2818 (1-800-977-6757 TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$800 individual/\$1,600 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, imaging, <a href="#">diagnostic tests</a> and generic drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network</a> \$2,400 individual/\$4,800 family. No, for <a href="#">non-network providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">Find a Provider</a> or call 1-800-289-2818 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$15 <a href="#">Copay</a> /visit; <a href="#">deductible</a> does not apply.	Not covered	----None----
	<a href="#">Specialist</a> visit	\$20 <a href="#">Copay</a> /visit; <a href="#">deductible</a> does not apply.	Not covered	Prior authorization required. Failure to obtain prior authorization for any service that requires prior authorization may result in denial of payment for care that may otherwise be covered.
	<a href="#">Preventive care/ screening/ immunization</a>	No charge	Not covered	----None----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">Copay</a> /test; <a href="#">deductible</a> does not apply.	Not covered	Prior authorization required.
	Imaging(CT/PET scans, MRIs)	\$100 <a href="#">Copay</a> /test; <a href="#">deductible</a> does not apply.	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> .	Generic Drugs (Tier 1)	No charge	Not covered	None. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	Preferred brand drugs (Tier 2)	\$25 <u>Copay</u>	Not covered	Prior authorization required. Prescription drugs are provided for up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	Non-preferred brand drugs (Tier 3)	\$40 <u>Copay</u>	Not covered	Prior authorization required. Prescription drugs are provided for up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	<a href="#">Specialty drugs</a> (Tier 4)	15% <u>Coinsurance</u>	Not covered	Prior authorization required. Prescription drugs are provided for up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <u>Copay</u> /visit: <u>deductible</u> does not apply	\$75 <u>Copay</u> /visit: <u>deductible</u> does not apply	----None----
	<a href="#">Emergency Medical transportation</a>	15% <u>Coinsurance</u>	15% <u>Coinsurance</u>	----None----
	<a href="#">Urgent Care</a>	\$50 <u>Copay</u> /visit: <u>deductible</u> does not apply	Not covered	----None----

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>Copay</u> /office visit; <u>deductible</u> does not apply; 15% <u>coinsurance</u> for all other outpatient services	Not covered	Prior authorization required. (PCP and Other Practitioner visits do not require prior authorization)
	Inpatient services	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
If you are pregnant	Office visits	\$15 <u>Copay</u> /visit; <u>deductible</u> does not apply	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <u>Coinsurance</u>	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	15% <u>Coinsurance</u>	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <u>Coinsurance</u>	Not covered	Prior authorization required. 42 visits per year.
	<a href="#">Rehabilitation services</a>	\$20 <u>Copay</u> /visit; <u>deductible</u> does not apply.	Not covered	Prior authorization required. 60 visits per year.
	<a href="#">Habilitation services</a>	15% <u>Coinsurance</u>	Not covered	Prior authorization required. 60 visits per year.
	<a href="#">Skilled nursing care</a>	15% <u>Coinsurance</u>	Not covered	Prior authorization required. 90 days per year.
	<a href="#">Durable medical equipment</a>	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
	<a href="#">Hospice services</a>	15% <u>Coinsurance</u>	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	\$0 <u>Copay</u> /visit; <u>deductible</u> does not apply	Not covered	1 Visit per Year
	Children's glasses	\$0 <u>Copay</u> /item; <u>deductible</u> does not apply	Not covered	1 Item per Year
	Children's dental check-up	Not covered	Not covered	-----None-----

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

- Bariatric surgery
- Private-duty nursing (Covered when medically necessary)
- Chiropractic care
- Routine foot care (Covered only in connection with the treatment of diabetes)
- Hearing aids

**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: Arizona Department of Insurance, 2910 N. 44th Street, Ste. 210 (2nd Floor) Phoenix, AZ 85018-7269, Phone No. (602) 364-2499 or (800) 325-2548. 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](http://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: Arizona Department of Insurance, 2910 N. 44th Street, Ste. 210 (2nd Floor) Phoenix, AZ 85018-7269, Phone No. (602) 364-2499 or (800) 325-2548)

#### **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 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne 1-888-926-5057 (TTY/TDD 1-888-926-5180).

—————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](#) \$800
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

**This EXAMPLE even includes services like:**

Specialist office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery facility Services  
 Diagnostic test (ultrasounds and blood work)  
 Specialist visit (anesthesia)

**Total Example Cost** \$12,800

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

Cost Sharing	
Deductibles	\$600
Copayments	\$500
Coinsurance	\$1,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,460</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

**This EXAMPLE even includes services like:**

Primary care physician office visits (includes disease education)  
 Diagnostic tests (blood work)  
 Prescription Drugs  
 Durable medical equipment (glucose meter)

**Total Example Cost** \$7,400

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

Cost Sharing	
Deductibles	\$800
Copayments	\$700
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,860</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$800
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

**This EXAMPLE even includes services like:**

Emergency room care (including medical supplies)  
 Diagnostic test (x-ray)  
 Durable medical equipment (crutches)  
 Rehabilitation services (Physical therapy)

**Total Example Cost** \$1,900

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

Cost Sharing	
Deductibles	\$800
Copayments	\$100
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at **1-888-926-5057 (TTY: 711)**.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



<b>Spanish:</b>	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Health Net, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Navajo:</b>	Ni da éí doodago háida biká anilyeedígíí Ambetter from Health Net yina 'idilkidgo t'áá ni nizaad k'ehji níká a'doowol dóó hazhó'ó bee nil hoodonihgo bee ná haz'á dóó bááh ílinígóó. Ata' halne 'ígíí la' bich'í'í' hadeesdzih nínízingo koji' hólne' 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Chinese:</b>	如果您，或是您正在協助的對象，有關於 Ambetter from Health Net 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-888-926-5057 (TTY/TDD 1-888-926-5180)。
<b>Vietnames e:</b>	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Health Net, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Arabic:</b>	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Health Net ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Tagalog:</b>	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Health Net, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Korean:</b>	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Health Net 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-926-5057 (TTY/TDD 1-888-926-5180) 로 전화하십시오.
<b>French:</b>	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Health Net, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>German:</b>	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Health Net hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-926-5057 (TTY/TDD 1-888-926-5180) an.
<b>Russian:</b>	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Health Net вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-888-926-5057 (TTY/TDD 1-888-926-5180).
<b>Japanese:</b>	Ambetter from Health Net について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-888-926-5057 (TTY/TDD 1-888-926-5180) までお電話ください。
<b>Persian:</b>	اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Health Net دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-888-926-5057 (TTY/TDD 1-888-926-5180) تماس بگیرید.
<b>Syriac:</b>	ان اتلوخون خورنه ميقورى المساعدة بمصيتون متلثلتن اللوا مشى Ambetter from Health Net بمصيتون ميقريوتن المساعدة، وخنى لا شتلق زوزة منوخن . ان اتلوخون بارا الانى مندى، وان مترجم رقم تلفون 1-888-926-5057 (TTY/TDD 1-888-926-5180)
<b>Serbo-Croatian:</b>	Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Health Net, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-888-926-5057 TTY/TDD 1-888-926-5180).
<b>Thai:</b>	หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้มีความเกี่ยวข้องกับ Ambetter from Health Net ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการใช้บริการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-888-926-5057 (TTY: 711).