



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://www.ambetterhealth.com/en/ca/2027-brochures.html> or call 1-888-926-4988 (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 1-888-926-4988 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 at Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> at non-IHCP; or \$0 individual / \$0 family	See the Common Medical Events chart below for your cost for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. There is no <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$9,600 individual / \$19,200 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://www.ambetterhealth.com/en/ca/findadoc or call 1-888-926-4988 (TTY: 711) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 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			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$40 Copay / visit	Not covered	None Cost sharing waived at non-IHCP with IHCP referral .
	Specialist visit	No charge	\$80 Copay / visit	Not covered	None Cost sharing waived at non-IHCP with IHCP referral .
	Preventive care/screening/immunization	No charge	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	\$40 Copay / visit for laboratory & professional services \$85 Copay / visit for x-ray & diagnostic imaging \$150 Copay / visit for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. Cost sharing waived at non-IHCP with IHCP referral .
	Imaging (CT/PET scans, MRIs)	No charge	\$125 Copay / visit	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need drugs to treat your illness or condition More information about prescription	Generic drugs	No charge	Tier 1 - Retail: \$19 Copay / prescription Mail Order: \$38 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Cost sharing waived at non-IHCP with IHCP referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
drug coverage is available at https://www.ambetterhealth.com/en/ca/2027formulary	Preferred brand drugs	No charge	Tier 2 - Retail: \$60 Copay / prescription Mail Order: \$120 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Cost sharing waived at non-IHCP with IHCP referral .
	Non-preferred brand drugs and Non-preferred generic drugs	No charge	Tier 3 - Retail: \$90 Copay / prescription Mail Order: \$180 Copay / prescription	Not covered	
	Specialty drugs	No charge	Tier 4 - Retail: 20% Coinsurance . \$250 max	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail. Cost sharing waived at non-IHCP with IHCP referral
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Hospital/ASC: \$150 Copay / visit; Services other than surgery: 20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	\$75 Copay / visit	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need immediate medical attention	Emergency room care	No charge	\$350 Copay / visit	\$350 Copay / visit	None Cost sharing waived at non-IHCP with IHCP referral .
	Emergency medical transportation	No charge	\$250 Copay / visit	\$250 Copay / visit	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. Cost sharing waived at non-IHCP with IHCP referral .
	Urgent care	No charge	\$40 Copay / visit	\$40 Copay / visit	None Cost sharing waived at non-IHCP with IHCP referral .

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$375 Copay / day, up to 5 days	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Physician/surgeon fees	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit – individual therapy session: \$40 Copay / visit; Group therapy session: \$20 Copay / visit Other Outpatient Services: No charge	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.) Cost sharing waived at non-IHCP with IHCP referral .
	Inpatient services	No charge	\$375 Copay / day, up to 5 days	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If you are pregnant	Office visits	No charge	Prenatal: No charge; Postnatal: \$40 Copay / visit	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of services, coinsurance , deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
	Childbirth/delivery professional services	No charge	No charge	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services , such as routine pre-natal and post-natal screenings . Depending on the type of services, coinsurance , deductible or copayment may
	Childbirth/delivery facility services	No charge	\$375 Copay / day, up to 5 days	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
					apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Cost sharing waived at non-IHCP with IHCP referral .
If you need help recovering or have other special health needs	Home health care	No charge	\$30 Copay / visit	Not covered	Prior authorization may be required. Limited to 100 Visits Per Year. Cost sharing waived at non-IHCP with IHCP referral .
	Rehabilitation services	No charge	Outpatient: \$40 Copay / visit Inpatient: No charge	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Habilitation services	No charge	Outpatient: \$40 Copay / visit Inpatient: \$375 Copay / day, up to 5 days	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Skilled nursing care	No charge	\$150 Copay / day, up to 5 days	Not covered	Prior authorization may be required. Limited to 100 days per year. Cost sharing waived at non-IHCP with IHCP referral .
	Durable medical equipment	No charge	20% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
	Hospice services	No charge	No charge	Not covered	Prior authorization may be required. Covered No Limit. Cost sharing waived at non-IHCP with IHCP referral .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Limited to 1 exam per year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's glasses	No charge	No charge	Not covered	Limited to 1 Item Per Year. Cost sharing waived at non-IHCP with IHCP referral .
	Children's dental check-up	No charge	No charge	Not covered	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](#).)

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|-----------------------|--|---|
| • Chiropractic care | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (Exclusion does not apply to preventive care behavioral interventions) |
| • Hearing aids | | |

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

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| • Abortion (Termination of pregnancy and related services are covered in full) | • Bariatric surgery | • Routine eye care (Adult visit & screenings /eye refraction for vision correction purposes) |
| • Acupuncture (Covered when medically necessary) | | |

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>
- 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.dmhca.gov.
- Office of Personnel Management Multi-State Plan Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>.
- Healthcare.gov: www.HealthCare.gov or call 1-800-318-2596 or state health insurance [marketplace](#) or SHOP.

For more information on your rights to continue coverage, contact the plan at 1-800-839-2172. 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 on how 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 1-800-839-2172, submit a grievance form through www.myhealthnetca.com, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348.
- 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.dmhca.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? Not Applicable

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 1-888-926-4988 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-4988 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-4988 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-926-4988 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-926-4988 (TTY: 711) uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-926-4988 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-926-4988 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-926-4988 (TTY: 711).

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	\$80
■ Hospital (facility) copayment	\$375
■ 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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	\$80
■ Hospital (facility) copayment	\$375
■ 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*)

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

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$375
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*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:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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