



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 <a href="#">deductible</a> ?                                | \$4,700 individual / \$9,400 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> services, primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> visits, and certain <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> (see additional information below). | 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 <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . 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?              | Yes, \$50 individual / \$100 family for <a href="#">prescription drug coverage</a> . There are no other specific <a href="#">deductibles</a> .                                                                                                                                   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$11,650 individual / \$23,300 family. Not applicable for <a href="#">out-of-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="https://www.ambetterhealth.com/en/ca/findadoc">https://www.ambetterhealth.com/en/ca/findadoc</a> or call 1-888-926-4988 (TTY: 711) 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</a> charge 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. |

| Important Questions                                                          | Answers | Why This Matters:                                                                                                                                                                                                    |
|------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes.    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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                                                                                                                                                                                                                                                                                                                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                     |
|------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                         | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                            |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                        | Not covered                                        | None                                                                                                                                                                                                                                                                       |
|                                                                        | <a href="#">Specialist</a> visit                        | \$100 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                       | Not covered                                        | None                                                                                                                                                                                                                                                                       |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                                                 | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                  |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply for laboratory & professional services<br>\$95 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply for x-ray & diagnostic imaging<br>30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply 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. |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | \$325 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not                                                                                                                                                                                                                                                                                                                                             | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                     |

| Common Medical Event                                                                                                                                                                                                                                                                                                 | Services You May Need                                     | What You Will Pay                                                                                                                                                                                                  |                                                    | Limitations, Exceptions, & Other Important Information                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                      |                                                           | Network Provider<br>(You will pay the least)                                                                                                                                                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                      |                                                           | apply                                                                                                                                                                                                              |                                                    |                                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://www.ambetterhealth.com/en/ca/2027forulary">prescription drug coverage</a> is available at <a href="https://www.ambetterhealth.com/en/ca/2027forulary">https://www.ambetterhealth.com/en/ca/2027forulary</a> . | Generic drugs                                             | Tier 1 - Retail: \$20 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply<br>Mail Order: \$40 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply          | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. |
|                                                                                                                                                                                                                                                                                                                      | Preferred brand drugs                                     | Tier 2 - Retail: \$65 <a href="#">Copay</a> / prescription; subject to Rx drug <a href="#">deductible</a><br>Mail Order: \$130 <a href="#">Copay</a> / prescription; subject to Rx drug <a href="#">deductible</a> | Not covered                                        | Prior authorization may be required. <a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. |
|                                                                                                                                                                                                                                                                                                                      | Non-preferred brand drugs and Non-preferred generic drugs | Tier 3 - Retail: \$95 <a href="#">Copay</a> / prescription; subject to Rx drug <a href="#">deductible</a><br>Mail Order: \$190 <a href="#">Copay</a> / prescription; subject to Rx drug <a href="#">deductible</a> | Not covered                                        |                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                      | <a href="#">Specialty drugs</a>                           | Tier 4 - Retail: 20% <a href="#">Coinsurance</a> ; subject to Rx drug <a href="#">deductible</a> . \$250 max applies after <a href="#">deductible</a> is met                                                       | Not covered                                        |                                                                                                                                                 |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)            | Hospital/ASC: 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply;<br>Services other than surgery: 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a>                            | Not covered                                        | Prior authorization may be required. Covered No Limit.                                                                                          |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                                                                 |                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                      | Out-of-Network Provider<br>(You will pay the most)                             |                                                                                                                                                                                |
|                                                                           |                                                  | does not apply                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                       | Not covered                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$400 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                    | \$400 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply | None                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$250 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                    | \$250 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply | Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.                         |
|                                                                           | <a href="#">Urgent care</a>                      | \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                     | \$50 <a href="#">Copay</a> / visit                                             | None                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                   | Not covered                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                       | Not covered                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit – individual therapy session: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply; Group therapy session: \$25 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply<br>Other Outpatient Services: No charge; <a href="#">deductible</a> does not apply | Not covered                                                                    | Prior authorization may be required. Covered No Limit. ( <a href="#">Primary Care Provider</a> (PCP) and other practitioner office visits do not require prior authorization.) |
|                                                                           | Inpatient services                               | 30% <a href="#">Coinsurance</a>                                                                                                                                                                                                                                                                                   | Not covered                                                                    | Prior authorization may be required. Covered No Limit.                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | Prenatal: No charge; <a href="#">deductible</a> does not                                                                                                                                                                                                                                                          | Not covered                                                                    | Prior authorization not required for deliveries within the standard timeframe per federal                                                                                      |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                                                                                                                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                |                                           | apply; Postnatal: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                     |                                                    | regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                           |
|                                                                | Childbirth/delivery professional services | 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply                                                                                                         | Not covered                                        | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                | Childbirth/delivery facility services     | 30% <a href="#">Coinsurance</a>                                                                                                                                                     | Not covered                                        | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal and post-natal <a href="#">screenings</a> . Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$45 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                       | Not covered                                        | Prior authorization may be required. Limited to 100 Visits Per Year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Rehabilitation services</a>   | Outpatient: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply<br>Inpatient: 30% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply | Not covered                                        | Outpatient: Prior authorization may be required. Covered No Limit.<br>Inpatient: Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                | <a href="#">Habilitation services</a>     | Outpatient: \$50 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply<br>Inpatient: 30% <a href="#">Coinsurance</a>                                             | Not covered                                        | Outpatient: Prior authorization may be required. Covered No Limit.<br>Inpatient: Prior authorization may be required. Covered No Limit.                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                | <a href="#">Skilled nursing care</a>      | 30% <a href="#">Coinsurance</a>                                                                                                                                                     | Not covered                                        | Prior authorization may be required. Limited                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                           |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                                           | Network Provider<br>(You will pay the least)                                | Out-of-Network Provider<br>(You will pay the most) |                                                        |
|                                        |                                           |                                                                             |                                                    | to 100 days per year.                                  |
|                                        | <a href="#">Durable medical equipment</a> | 20% <a href="#">Coinsurance</a> ; <a href="#">deductible</a> does not apply | Not covered                                        | Prior authorization may be required. Covered No Limit. |
|                                        | <a href="#">Hospice services</a>          | No charge; <a href="#">deductible</a> does not apply                        | Not covered                                        | Prior authorization may be required. Covered No Limit. |
| If your child needs dental or eye care | Children's eye exam                       | No charge; <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to 1 exam per year.                            |
|                                        | Children's glasses                        | No charge; <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to 1 Item Per Year.                            |
|                                        | Children's dental check-up                | No charge; <a href="#">deductible</a> does not apply                        | Not covered                                        | Limited to 1 check-up every 6 months                   |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                             |                                                                                                                                                                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>                                                  | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs (Exclusion does not apply to <a href="#">preventive care</a> behavioral interventions)</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                           |                                                                     |                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion (Termination of pregnancy and related services are covered in full)</li> <li>Acupuncture (Covered when <a href="#">medically necessary</a>)</li> </ul> | <ul style="list-style-type: none"> <li>Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult visit &amp; <a href="#">screenings</a>/eye refraction for vision correction purposes)</li> </ul> |

**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.dmhc.ca.gov](http://www.dmhc.ca.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](http://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](http://www.HealthCare.gov) or call 1-800-318-

**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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$4,700        |
| <a href="#">Copayments</a>        | \$800          |
| <a href="#">Coinsurance</a>       | \$1,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,660</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$50           |
| <a href="#">Copayments</a>        | \$1,700        |
| <a href="#">Coinsurance</a>       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,970</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,700 |
| ■ <a href="#">Specialist copayment</a>                          | \$100   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

#### This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$40           |
| <a href="#">Copayments</a>        | \$1,400        |
| <a href="#">Coinsurance</a>       | \$50           |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,490</b> |

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

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.