



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 deductible ?	\$200 individual / \$400 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care services, primary care, specialist , and urgent care visits, and certain prescription drugs are covered before you meet your deductible (see additional information below).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers : \$3,000 individual / \$6,000 family. Not applicable for out-of-network providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See https://www.ambetterhealth.com/en/ca/findadoc or call 1-888-926-4988 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you

Important Questions	Answers	Why This Matters:
see a specialist ?		have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$5 Copay / visit; deductible does not apply	Not covered	None
	Specialist visit	\$8 Copay / visit; deductible does not apply	Not covered	None
	Preventive care/screening /immunization	No charge; deductible does not apply	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)	\$10 Copay / visit; deductible does not apply for laboratory & professional services \$10 Copay / visit; deductible does not apply for x-ray & diagnostic imaging 10% Coinsurance ; deductible 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)	\$50 Copay / visit; deductible does not apply	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.ambetterhealth.com/en/ca/2027formulary	Generic drugs	Tier 1 - Retail: \$3 Copay / prescription; deductible does not apply Mail Order: \$6 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Preferred brand drugs	Tier 2 - Retail: \$10 Copay / prescription; deductible does not apply Mail Order: \$20 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs 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: \$15 Copay / prescription; deductible does not apply Mail Order: \$30 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Specialty drugs	Tier 4 - Retail: 10% Coinsurance ; deductible does not apply. \$150 max	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital/ASC: 10% Coinsurance ; deductible does not apply; Services other than surgery: 10% Coinsurance ; deductible does not apply	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	10% Coinsurance ;	Not covered	Prior authorization may be required. Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		deductible does not apply		No Limit.
If you need immediate medical attention	Emergency room care	\$50 Copay / visit; deductible does not apply	\$50 Copay / visit; deductible does not apply	None
	Emergency medical transportation	\$30 Copay / visit; deductible does not apply	\$30 Copay / visit; deductible does not apply	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	\$5 Copay / visit; deductible does not apply	\$5 Copay / visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	10% Coinsurance ; deductible 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: \$5 Copay / visit; deductible does not apply; Group therapy session: \$2.50 Copay / visit; deductible does not apply Other Outpatient Services: No charge; deductible does not apply	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)
	Inpatient services	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	Prenatal: No charge; deductible does not apply; Postnatal: \$5 Copay / visit; deductible	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		does not apply		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).
	Childbirth/delivery professional services	10% Coinsurance ; deductible 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. 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).
	Childbirth/delivery facility services	10% Coinsurance	Not covered	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).
If you need help recovering or have other special health needs	Home health care	\$3 Copay / visit; deductible does not apply	Not covered	Prior authorization may be required. Limited to 100 Visits Per Year.
	Rehabilitation services	Outpatient: \$5 Copay / visit; deductible does not apply Inpatient: 10% Coinsurance ; deductible does not apply	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: \$5 Copay / visit; deductible does not apply Inpatient: 10% Coinsurance	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	10% Coinsurance	Not covered	Prior authorization may be required. Limited to 100 days per year.
	Durable medical equipment	10% Coinsurance ; deductible does not	Not covered	Prior authorization may be required. Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		apply		No Limit.
	Hospice services	No charge; deductible 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; deductible does not apply	Not covered	Limited to 1 exam per year.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 1 Item Per Year.
	Children's dental check-up	No charge; deductible does not apply	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 .)			
- Chiropractic care - Cosmetic surgery - Dental care (Adult) - Hearing aids	- Infertility treatment - Long-term care - Non-emergency care when traveling outside the U.S.	- Private-duty nursing - Routine foot care - Weight loss programs (Exclusion does not apply to preventive care behavioral interventions)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
- Abortion (Termination of pregnancy and related services are covered in full) - Acupuncture (Covered when medically necessary)	Bariatric surgery	Routine eye care (Adult visit & screenings/eye refraction for vision correction purposes)	

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.
- 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.dmhc.ca.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at the contact information provided above.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? 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	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$200
Copayments	\$200
Coinsurance	\$800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,260

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$400
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$8
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$40
Copayments	\$200
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$260

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