



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?	Network providers : \$12,000 Individual/ \$24,000 Family. Out-of-network providers : \$24,000 Individual / \$48,000 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 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 : \$12,000 Individual / \$24,000 Family. For out-of-network providers : \$25,000 Individual / \$50,000 Family.	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, penalties for failure to obtain preauthorization for services, 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

Important Questions	Answers	Why This Matters:
		work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 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	No charge. Deductible is waived for the first 3 non-preventive visits	50% Coinsurance	None
	Specialist visit	No charge	50% Coinsurance	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)	No charge for laboratory & professional services No charge for x-ray & diagnostic imaging No charge for laboratory & professional services and x-ray & diagnostic imaging at other places of service	50% Coinsurance for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	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)	No charge	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition More information about	Generic drugs	Tier 1 - Retail: No charge Mail Order: No charge	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.

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)	
prescription drug coverage is available at https://www.ambetterhealth.com/en/ca/2027formulary .	Preferred brand drugs	Tier 2 - Retail: No charge Mail Order: No charge	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: No charge Mail Order: No charge	Not covered	
	Specialty drugs	Tier 4 - Retail: No charge	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: No charge; Services other than surgery: No charge	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	No charge. Deductible is waived for the first 3 non-preventive visits	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% Coinsurance	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	50% Coinsurance	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: No charge. Deductible is waived for the first 3	50% Coinsurance	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and other practitioner office visits do not require prior authorization.)

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)	
		non-preventive visits; Group therapy session: No charge. Deductible is waived for the first 3 non-preventive visits Other Outpatient Services: No charge		
	Inpatient services	No charge	50% Coinsurance	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	Prenatal: No charge; deductible does not apply; Postnatal: No charge. Deductible is waived for the first 3 non-preventive visits	50% Coinsurance	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 professional services	No charge	50% Coinsurance	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	No charge	50% Coinsurance	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).
If you need help recovering or have	Home health care	No charge	Not covered	Prior authorization may be required. Limited to 100 Visits Per Year.

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)	
other special health needs	Rehabilitation services	Outpatient: No charge Inpatient: No charge	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: No charge Inpatient: No charge	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Covered No Limit.
	Skilled nursing care	No charge	50% Coinsurance	Prior authorization may be required. Limited to 100 days per year.
	Durable medical equipment	No charge	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	No charge	50% Coinsurance	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 once 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)	Bariatric surgery	Routine eye care (Adult visit & screenings/eye refraction for vision correction purposes)

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie 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	\$12,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles*	\$12,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$12,060

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$12,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$4,700
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,720

Mia's Simple Fracture

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

■ The plan's overall deductible	\$12,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

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