



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 www.healthnet.com or call 1-800-522-0088. 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 www.healthnet.com or you can call 1-800-522-0088 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u> ?	There is no <u>deductible</u> through <u>preferred providers</u> ; \$4,000 member/\$12,000 family through <u>out-of-network providers</u> per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	There is no <u>deductible</u> through <u>preferred providers</u> .	There is no deductible through <u>preferred providers</u> . You will however, have to meet the <u>out-of-network deductible</u> before the <u>plan</u> pays for any <u>out-of-network</u> services, except for services indicated in chart starting on Page 2.

* For more information about limitations and exceptions, see the **plan** or policy document at www.healthnet.com.

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Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital/ASC-No charge Services other than surgery- No charge	50% <u>coinsurance</u>	Some outpatient surgical procedures require <u>prior authorization</u> . If <u>prior authorization</u> is not obtained, out-of-

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For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	Prenatal/Postnatal-No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	Some services require <u>prior authorization</u> .
	<u>Rehabilitation services</u>	\$5 <u>copay</u> /visit	50% <u>coinsurance</u>	Some services require <u>prior authorization</u> . If <u>prior authorization</u> is not obtained, out-of-network benefits will be reduced to 50% <u>coinsurance</u> .

* For more information about limitations and exceptions, see the plan or policy document at www.healthnet.com.

Excluded Services & Other Covered Services:

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

Bariatric surgery
Chiropractic care-\$10 copay/visit (PPO) up to 30 visits per calendar year. Administered by American Specialty Health (ASH).
Chiropractic care is not covered out-of-network.

Infertility treatment-covered through PPO only. Infertility treatment is not covered out-of-network.

Your Rights to Continue Coverage:

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

▪ The plan's overall deductible	\$0
▪ Specialist copayment	\$15
▪ Hospital (facility) copayment	\$0
▪ Other copayment	\$0

Managing Joe's Type 2 Diabetes

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

▪ The plan's overall deductible	\$0
▪ Specialist copayment	\$15

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (*ultrasounds and blood work*)

Specialist visit (*anesthesia*)

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

Cost Sharing	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

HEALTH NET:

Characteristics listed above can be a source of health care discrimination. Customer contact center at toll-free 1-800-237-1234 and telemedicine provider at 1-800-237-1234. Customer contact center is accessible to hearing impaired individuals and via email at:

HealthNet of California HealthNet Insurance Company of California

Health Net Inc.

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Email nondiscrimination complaints to: complaints@healthnet.com

Non-discrimination complaints to: complaints@hni.com

HealthNet is committed to providing a complaint resolution process that is fair and timely. If you believe you have been discriminated against, please file a complaint with HealthNet of California and are not satisfied with the decision or it has been more than 60 days since you filed a complaint with HealthNet of California, you may file an independent discrimination claim with the Department of Health Care Services. You may file a complaint with the California Office of Health Care Access and Transformation online at:

Independent Claim

If you believe you have been discriminated against because of race, color, national origin, gender, sex, gender identity, gender expression, or disability, you may file a discrimination complaint with the Department of Health Care Services or the California Office of Health Care Access and Transformation. You may file a discrimination complaint with the California Office of Health Care Access and Transformation online at: Department of Health Care Services Independence Administration or HH Administration.

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Comments are available at www.hhs.gov/ocr/complaints

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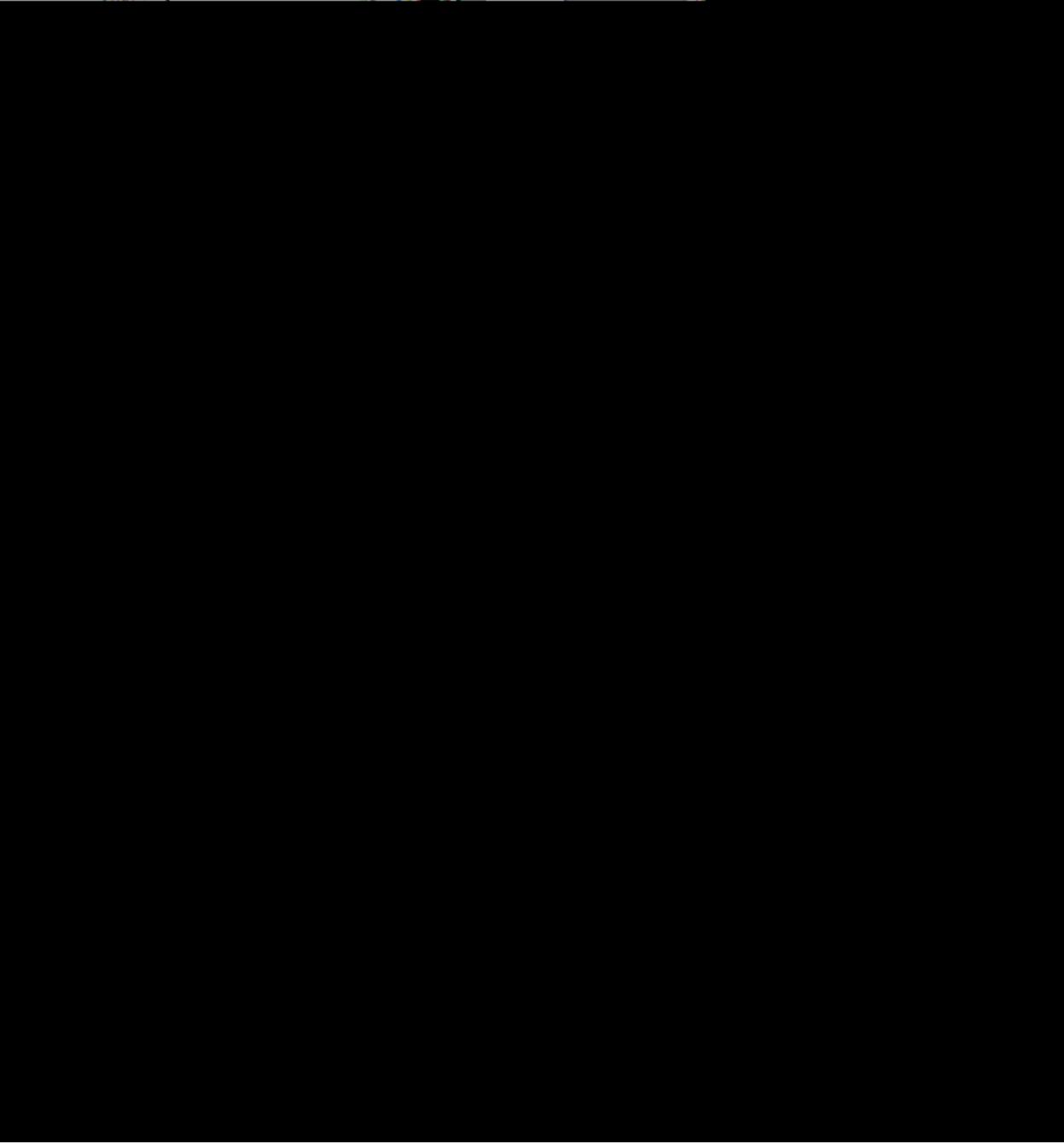
English

No CapA [REDACTED] [www.NoCapA.com](#) is a state-of-the-art, web-based software solution designed to help individuals and families navigate the complex world of health insurance. Our mission is to provide clear, concise information and guidance to help people make informed decisions about their healthcare coverage.

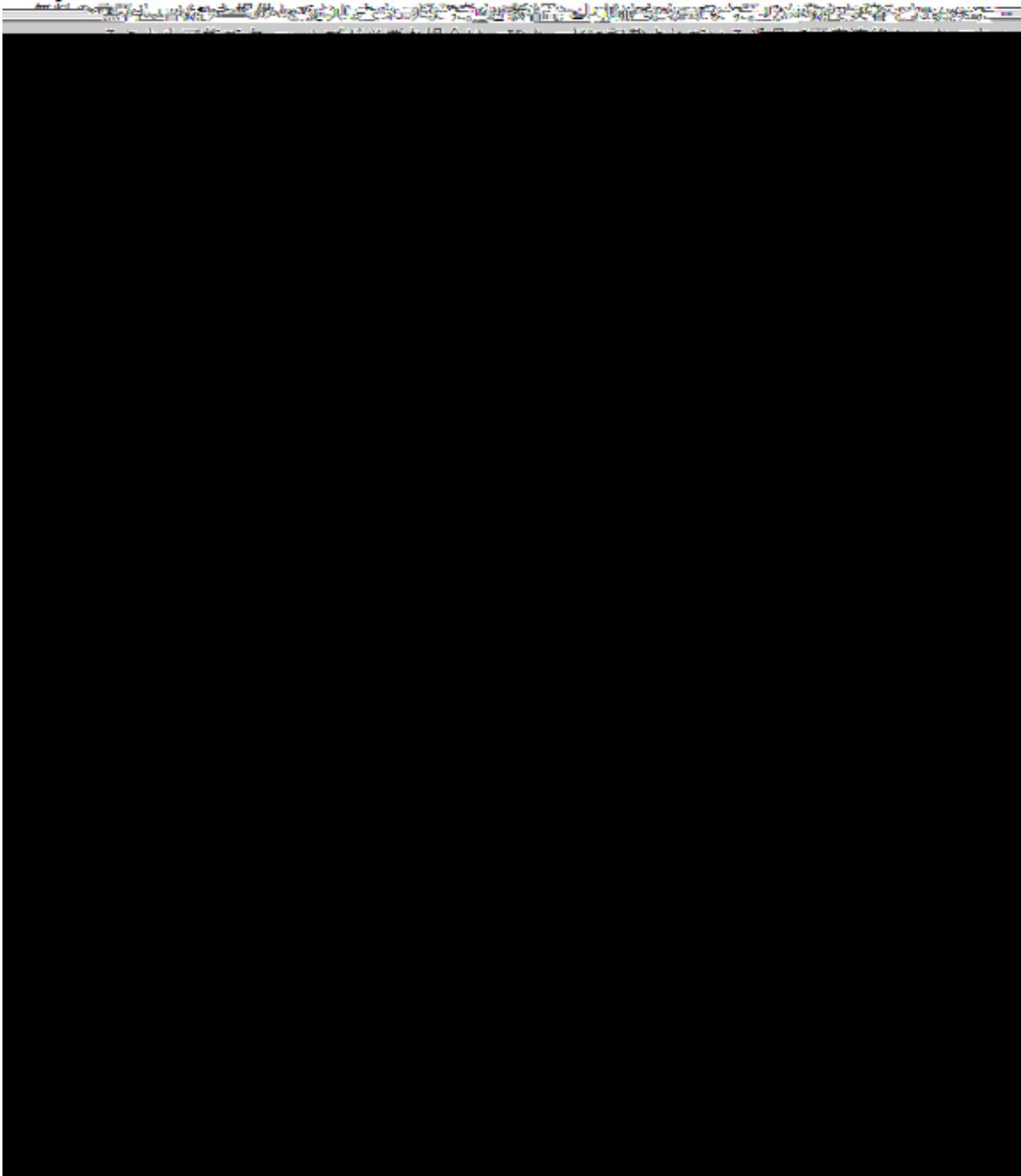
Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplaces, [www.CoverTheBasics.org](#) or [www.CoverTheBasics.ca.gov](#). For Massachusetts, call 1-800-729-2300 or [www.MassHealthCare.org](#).

To find a plan through No CapA, call 1-800-322-3088 (TTY: 711).

Arabic



Japanese



Punjabi (Punjabi)

ਪੰਜਾਬੀ ਕ੍ਰਿਤੀਗਲ ਕੇਂਦਰ ਵਿੱਚ ਬਹੁਮਿਥੀ ਪੱਧਰੀ ਮਨਜ਼ੂਰ ਸੂਚਨਾਵਾਂ ਦਿੱਤੀ ਜਾਂਦੀ ਹੈ। ਜਾਰੀ ਮੁਫ਼ਰਾਦ ਅਤੇ ਮਨਜ਼ੂਰ ਸੂਚਨਾਵਾਂ ਵਿੱਚੋਂ ਅਨੇਕ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਵੇਖ ਲੈ ਸਕੋਂ ਹੋਵੇਗਾ। ਕਿੱਵੇਂ ਕੰਪਨੀਆਂ ਨੂੰ ਆਪਣੇ ਪੰਜਾਬੀ ਮਨਜ਼ੂਰ ਸੂਚਨਾਵਾਂ ਵਿੱਚ ਦੇਣਾ ਜਾਂ ਏਕ ਅਤੇ ਅੱਕਸ਼ਮੁਲਾਕ ਮਨਜ਼ੂਰ ਵੇਖੋਂ ਲੇਣਾ ਜਾਂ ਉਪਰਾਂ ਵਿੱਚ ਲੇਖਕ ਦੀ ਜ਼ਰੂਰਤ ਹੋ ਜਾਂਦੀ ਹੈ।

ਮਾਰਕੀਟਪਲੇਸ ਲਈ, IFP ਐਨ ਐਕਸਾਏਜ਼ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਪੋਲ ਬਿਜ਼ਨੇਸ ਨੂੰ

1-888-926-4988 (TTY: 711) ਜਾਂ ਸਪੋਲ ਬਿਜ਼ਨੇਸ ਨੂੰ ਬੋਲ ਸਕਿਸ਼ਣ ਕਰ ਸਕਦੇ ਹੋਣੇ ਲਈ ਵਰਤੋਂ ਕਰ ਸਕਦੇ ਹਨ।

Russian

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