

# Plan Overview

## SMARTCARE

30/20% (\$2,500 / \$5,000)

| Benefit description                                                                                                                                                        | Member responsibility                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| <b>Plan maximums</b>                                                                                                                                                       |                                             |
| Out-of-pocket maximum (combined with Rx) (Individual / Family)                                                                                                             | \$2,500 / \$5,000                           |
| <b>Facility deductible</b>                                                                                                                                                 |                                             |
| Deductible applies to inpatient hospital, skilled nursing facility, outpatient facility services, outpatient surgery, and ER facility benefits only. (Individual / Family) | N/A / N/A                                   |
| <b>Professional services</b>                                                                                                                                               |                                             |
| PCP Office visit <sup>1</sup>                                                                                                                                              | \$30                                        |
| Specialist Office visit <sup>1</sup>                                                                                                                                       | \$50                                        |
| Preventive care services <sup>1</sup>                                                                                                                                      | \$0                                         |
| Telehealth services through the Select Telehealth Services Provider <sup>2</sup>                                                                                           | \$0                                         |
| Rehabilitation therapy <sup>3</sup>                                                                                                                                        | \$30                                        |
| X-ray procedures <sup>1</sup>                                                                                                                                              | \$15                                        |
| Laboratory procedures <sup>1</sup>                                                                                                                                         | \$15                                        |
| Complex radiology services (includes CT, SPECT, PET, MUGA, and MRI)                                                                                                        | 20%                                         |
| <b>Facility services</b>                                                                                                                                                   |                                             |
| Outpatient services (hospital)                                                                                                                                             | 20%                                         |
| Outpatient services (ambulatory surgery center)                                                                                                                            | 10%                                         |
| Inpatient hospital                                                                                                                                                         | 20%                                         |
| Skilled nursing facility (100 day maximum)                                                                                                                                 | Days 1-10: \$0<br>Days 11-100: \$25 per day |
| <b>Emergency services</b>                                                                                                                                                  |                                             |
| Urgent care services                                                                                                                                                       | \$30                                        |
| Emergency room facility                                                                                                                                                    | \$150                                       |
| Ambulance services (ground and air)                                                                                                                                        | \$150                                       |
| <b>Mental health and substance use disorder services</b>                                                                                                                   |                                             |
| Outpatient office visit                                                                                                                                                    | \$30                                        |
| Outpatient other (includes partial hospitalization/day treatment/intensive outpatient programs)                                                                            | 20%                                         |
| Inpatient                                                                                                                                                                  | 20%                                         |
| <b>Other services</b>                                                                                                                                                      |                                             |
| Durable medical equipment <sup>1</sup>                                                                                                                                     | \$0                                         |
| Diabetic equipment                                                                                                                                                         | \$0                                         |
| Acupuncture services <sup>4</sup>                                                                                                                                          | Rider available                             |
| Chiropractic services <sup>4</sup>                                                                                                                                         | Rider available                             |

<sup>1</sup> Preventive care services are covered for children and adults based on guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC); and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

<sup>2</sup> Listed cost share is for services provided through the Select Telehealth Services Provider; for all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.

<sup>3</sup> Rehabilitation therapy includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

<sup>4</sup> Chiropractic and/or Acupuncture rider coverage is included in all SmartCare HMO plans and is available as an optional benefit in all other HMO and EOA plans.

This is merely a brief summary of benefits. It does not include all covered services, limitations or exclusions. Please refer to the *Evidence of Coverage* for all terms and conditions of coverage.

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1/2026