Health Net of California, Inc. (Health Net)

Individual & Family Plans

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Individual & Family Ambetter HMO Plans

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to apply today!

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This document is only a summary of your health coverage. You have the right to view the Plan's *Plan Contract and Evidence of Coverage (EOC)* prior to enrollment. To obtain a copy of this document, contact your authorized Health Net Agent or your Health Net Sales Representative at 1-877-609-8711. The *Plan's Plan Contract and EOC,* which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and the Plan's *Plan Contract and EOC* thoroughly once you receive them, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices are included in this document to help you compare coverage benefits.

The coverage described in this *Disclosure Form* shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits. Coverage is limited to Essential Health Benefits and other benefits as required under applicable federal or state laws. Services that are not Essential Health Benefits and are not otherwise required to be covered under applicable federal or state laws, are not covered under the *Plan Contract*.

The benefits described under this *Disclosure Form* do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, and are not subject to any pre-existing condition or exclusion period.

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Please Read This Important Notice About the Health Net Ambetter HMO Network Health Plan Service Area

AND OBTAINING SERVICES FROM AMBETTER HMO NETWORK PHYSICIANS AND HOSPITAL PROVIDERS AND AMBETTER PHARMACY NETWORK PHARMACIES

Except for Emergency Services and Care, benefits for Physician and Hospital services under this **Health Net Ambetter HMO Network Plan** are only available when you live in the Service Area and use an Ambetter HMO Network Physician or Hospital. When you enroll in this Ambetter HMO Network Plan, you may only use a Physician or Hospital who is in the Ambetter HMO Network, and you must choose an Ambetter HMO Network Primary Care Physician (PCP). You may obtain ancillary, pharmacy or behavioral health Covered Benefits and supplies from any Health Net participating ancillary, pharmacy or behavioral health provider.

Obtaining covered services under the Health Net Ambetter HMO Network plan

Type of provider	Hospital	Physician	Ancillary	Pharmacy	Behavioral health
Available from	*Only Ambetter HMO Network hospitals	*Only Ambetter HMO Network Physicians	All Health Net Contracting Ancillary Providers	Only Health Net Ambetter Pharmacy Network	All Health Net Contracting Behavioral Health providers

*The benefits of this Plan for Physician and Hospital services are only available for Covered Benefits received from an Ambetter HMO Network Physician or Hospital, except for (1) Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Services and Care; (2) referrals to non-Ambetter HMO Network providers are covered when the referral is issued by your Ambetter HMO Network Physician Group; and (3) Covered Benefits provided by a non-Ambetter HMO Network provider when authorized by Health Net.

Note: Not all Physician and hospitals that contract with Health Net are Ambetter HMO Network providers. Only those Physicians and hospitals specifically identified as participating in the Ambetter HMO Network may provide services under this Plan, except as described in the chart above.

The Service Area and a list of its Physician and Hospital providers are shown in the Health Net Ambetter HMO Network Provider Directory, which is available online at our website www.myhealthnetca.com. You can also call the Health Net Customer Contact Center at **1-877-609-8711** to request provider information. The Ambetter HMO Network Provider Directory is different from other Health Net Provider Directories.

Unless specifically stated otherwise, use of the following terms in this brochure solely refers to the Ambetter HMO Network as explained above.

- Health Net
- Service Area
- Hospital
- Member Physician, participating Physician Group, Primary Care Physician, Physician, participating provider, contracting Physician Groups and contracting providers
- Network
- Provider Directory

Health Net Ambetter Pharmacy Network

Not all pharmacies that contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency, only those pharmacies specifically identified as participating in the Ambetter Pharmacy Network may provide the Prescription Drugs benefit under this Plan. For a list of pharmacies participating in the Ambetter Pharmacy Network, call our Health Net Customer Contact Center or visit our website at **www.myhealthnetca.com.** Pharmacies that are not in the Ambetter Pharmacy Network are considered non-participating pharmacies under this Plan.

Unless specifically stated otherwise, use of the following terms in this Disclosure Form solely refers to the Ambetter Pharmacy Network as explained above.

- Participating Pharmacy
- Health Net contracting retail pharmacy
- Contracted pharmacy

If you have any questions about the Service Area, choosing your Ambetter HMO Network PCP, how to access Specialist care, or your benefits, please contact the Health Net Customer Contact Center at **1-877-609-8711.**

Health Net Individual & Family Coverage for You and Your Family

Health Net offers the following health care coverage options to individuals and families:

HMO – Our Individual & Family Plan Health Maintenance Organization (HMO) Plans are designed for people who would like one doctor to coordinate their medical care at predictable costs. You are required to choose a main doctor – called a Primary Care Physician (PCP) – from our Ambetter HMO Network. Your PCP oversees all of your health care and provides referral/authorization if specialty care is needed. When you choose one of our HMO Plans, you may only use a Physician or Hospital who is in the Health Net Ambetter HMO Network.

Is an HMO right for you?

With our Ambetter HMO Plans you are required to choose a PCP. Your PCP will provide and coordinate your medical care. You have the right to designate any PCP who participates in our Health Net Ambetter HMO network, has an office close enough to your residence to allow reasonable access to medical care and who is available to accept you or your Family Members, subject to the requirements of the Physician Group. For children, a pediatrician may be designated as the PCP. Until you make your PCP designation, Health Net designates one for you. Information on how to select a PCP and a listing of the participating PCP's in the Service Area are available on the Health Net website at **www.myhealthnetca.com.** You can also call **1-877-609-8711** to request provider information or contact your Health Net authorized broker.

Your PCP oversees all your health care and provides the referral/authorization if specialty care is needed. PCPs include general and family practitioners, internists, pediatricians and OB/GYNs. Many services require only a fixed Copayment from you. To obtain health care, simply present your ID card and pay the appropriate Copayment.

Your PCP must first be contacted for initial treatment and consultation before you receive any care or treatment through a Hospital, Specialist, or other Health Care Provider, except for OB/GYN visits and reproductive and sexual Health Care Services, as set out below. All treatments recommended by such providers must be authorized by your PCP.

You do not need Prior Authorization from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical, gynecological, reproductive or sexual Health Care Services from a health care from an in-network health care professional who specializes in obstetrics, gynecology, or reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment Plan, or procedures for making referrals. A listing of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health is available on the Health Net website at **www.myhealthnetca.com.**

You can also call **1-877-609-8711** to request provider information or contact your Health Net authorized broker. Refer to the "Mental Health or Substance Use Disorder Services" section in this document for information about receiving care for Mental Health or Substance Use Disorders.

Your PCP belongs to a larger group of health care professionals, called a participating Physician Group. If you need care from a Specialist, your PCP refers you to one within this group.

Calendar year deductible

For some HMO Plans, a Calendar Year Deductible is required for certain services and supplies and is applied to the Out-of-Pocket Maximum. See the benefit grids for specific information. You must pay an amount of Covered Expenses for noted services equal to the Calendar Year Deductible before the benefits are paid by your Plan. After the Deductible is satisfied, you remain financially responsible for paying any other applicable Copayments until you satisfy the individual or family Out-of-Pocket Maximum. If you are a Member in a family of two or more members, you reach the Deductible either when you meet the amount for any one Member, or when your entire family reaches the family amount. Family Deductibles are equal to two times the individual Deductible. If your Plan has a Calendar Year Deductible, that Deductible does not apply to adult dental and vision services benefits under the HMO Plus Plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" below). In addition, if your Plan has a Calendar Year Deductible,

Copayments for adult dental and vision services benefits under the HMO Plus Plans do not accrue toward that Deductible.

You will be notified by us of your Deductible accumulation for each month in which benefits were used. You will also be notified when you have reached your Deductible amount for the Calendar Year. You can obtain the most up-to-date accrual balance on your Deductible accumulation or request that your accrual balance be sent to you by email by calling the Customer Contact Center at the telephone number on your ID card.

Out-of-pocket maximum

Copayments and Deductibles that you or your Family Members pay for Covered Benefits and supplies apply toward the individual or family Out-of-Pocket Maximum(OOPM). The family OOPM is equal to two times the individual OOPM. After you or your Family Members meet your OOPM, you pay no additional amounts for Covered Benefits and supplies for the balance of the Calendar Year. Once an individual Member in a family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments and Deductibles until either (a) the aggregate of such Copayments and Deductibles paid by the family reaches the family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM. You are responsible for all charges related to services or supplies not covered by the health Plan. Payments for services or supplies not covered by this Plan will not be applied to this yearly OOPM. Copayments for adult dental and vision services benefits under the HMO Plus Plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" below) do not accrue toward your OOPM.

For the family OOPM to apply, you and your family must be enrolled as a family.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also be notified by us when you have reached your OOPM amount for the Calendar Year. You can obtain the most up-to-date accrual balance on your OOPM accumulation or request that your accrual balance be sent to you by email by calling the Customer Contact Center at the telephone number on your ID card.

Timely Access to Care

The California Department of Managed Health Care (DMHC) has issued regulations (California Code of Regulations Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency Health Care Services.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered Health Care Services in a timely manner. For further information, please refer to the Individual & Family Plan HMO *Plan Contract and EOC* or contact the Health Net Customer Contact Center at the phone number on the back cover.

Please see the "Notice of Language Services" at the end of this Disclosure Form for information regarding the availability of no cost interpreter services.

Optional Dental and Vision Coverage (for ages 19 and older)[1]

The Health Net Individual & Family Plans include pediatric dental and vision coverage for individuals under 19 years of age. Optional dental and vision coverage for ages 19 and older is available with Health Net Ambetter HMO Plus Plans. A Health Net "Plus" Plan is a Health Net HMO Plan with Health Net dental and vision coverage included. The "Plus" indicates the addition of the optional coverage. For more information, refer to the Plus Plan information found later in this guide or contact your authorized Health Net agent or call Health Net's Individual & Family Plans Department at **1-800-909-3447.**

[1]Dental and vision benefits provided by Health Net of California, Inc. Dental benefits administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC to provide and administer vision benefits.

Plan Overview – Platinum 90 Ambetter HMO

The Platinum 90 Ambetter HMO health Plan utilizes the **Ambetter HMO** provider network for Covered Benefits. **Ambetter HMO** is available through Covered California in Imperial, Los Angeles, Orange, San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

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The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$5,500 single/$11,000 family
Professional services Office visit copay[1]	$20
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$45
Other practitioner office visit (including medically necessary acupuncture)[3]	$20
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$35
Laboratory tests	$25
Imaging (CT, PET scans, MRIs)	$90
Rehabilitation and habilitation therapy	$20
Outpatient services Outpatient surgery	$100 facility / $50 physician
Hospital services Inpatient hospital stay (includes maternity)	Facility: $325/day (up to 5 days); Physician: $0
Skilled nursing facility (maximum of 100 days per calendar year for each member)	$175/day (up to 5 days)[5]
Emergency services Emergency room services (copays waived if admitted)	$225 facility / $0 physician
Urgent care	$20
Ambulance services (ground and air)	$150
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: $325/day (up to 5 days); Physician: $0
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $20; Other than office visit: $0
Home health care services (100 visits per calendar year)	$20
Other services Durable medical equipment	10%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$10
Tier 2 (non-preferred generics and preferred brand)	$25
Tier 3 (non-preferred brand)	$45

Benefit description	Member(s) responsibility
Tier 4 (Specialty drugs)[10]	10% up to $250/script
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

[1]Prenatal, postnatal, and newborn care office visits for Preventive Care Services, including preconception visits, are covered in full. See Copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other non-preventive services are received during the same office visit, a Copayment will apply for the non-preventive services.

[2]You may receive services on an in-person basis or via telehealth, if available, from your Primary Care Physician, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your Plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your Primary Care Physician.

[3]Includes acupuncture visits, physical, occupational and speech therapy visits, and other office visits not provided by either Primary Care or specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

[4]Preventive care services are covered for children and adults, as directed by your Physician, based on recommendations by the California Department of Public Health (CDPH), and guidelines from the U.S. Preventive Services Task Force (USPSTF) 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[5]No additional Copayment after the first 5 days of a continuous Skilled Nursing Facility stay.

[6]Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

[7]If the pharmacy's cost of the prescription is less than the applicable Copayment, then you will only pay the pharmacy's cost of the prescription.

[8] Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a brand-name preventive drug or contraceptive is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the Prescription Drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a Physician) under the medical benefit.

[9]The Ambetter by Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and Participating Pharmacies. Some drugs on the list may require Prior Authorization from Health Net. Drugs that are not listed on the list (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. Urgent requests from Physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted. For a copy of the Ambetter by Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com

Generic drugs will be dispensed when a Generic Drug equivalent is available. Health Net will cover Brand Name Drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3, or Tier 4 Copayment, when determined to be Medically Necessary.

[10]Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Ambetter by Health Net Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered.

[11]The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family *Plan Contract and EOC* for details.

[12]The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

Ambetter HMO plans are offered by Health Net of California, Inc. (Health Net). Health Net of California, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Plan Overview – Gold 80 Ambetter HMO

The Gold 80 Ambetter HMO health plan utilizes the **Ambetter HMO** provider network for Covered Benefits. **Ambetter HMO** is available through Covered California in Imperial, Los Angeles, Orange and San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

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The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$9,600 single/$19,200 family
Professional services Office visit copay[1]	$40
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$80
Other practitioner office visit (including medically necessary acupuncture)[3]	$40
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$85
Laboratory tests	$40
Imaging (CT, PET scans, MRIs)	$125
Rehabilitation and habilitation therapy	$40
Outpatient services Outpatient surgery	Facility: $150; Physician: $75
Hospital services Inpatient hospital stay (includes maternity)	Facility: $375/day (up to 5 days); Physician: $0
Skilled nursing care facility (maximum of 100 days per calendar year for each member)	$150/day (up to 5 days)[5]
Emergency services Emergency room services (copays waived if admitted)	Facility: $350; Physician: $0
Urgent care	$40
Ambulance services (ground and air)	$250
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: $375/day (up to 5 days); Physician: $0
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $40; Other than office visit: $0
Home health care services (100 visits per calendar year)	$30
Other services Durable medical equipment	20%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$19
Tier 2 (non-preferred generics and preferred brand)	$60
Tier 3 (non-preferred brand)	$90

Benefit description	Member(s) responsibility
Tier 4 (Specialty drugs)[10]	20% up to $250/script
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

[1]Prenatal, postnatal and newborn care office visits for Preventive Care Services, including preconception visits, are covered in full. See Copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other non-preventive services are received during the same office visit, a Copayment will apply for the non-preventive services.

[2]You may receive services on an in-person basis or via telehealth, if available, from your Primary Care Physician, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your Plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your Primary Care Physician.

[3]Includes acupuncture visits, physical, occupational and speech therapy visits, and other office visits not provided by either Primary Care or specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

[4]Preventive care services are covered for children and adults, as directed by your Physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[5]No additional Copayment after the first 5 days of a continuous Skilled Nursing Facility stay.

[6]Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

[7]If the pharmacy's cost of the prescription is less than the applicable Copayment, then you will only pay the pharmacy's cost of the prescription.

[8]Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a brand-name preventive drug or contraceptive is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the Prescription Drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a Physician) under the medical benefit.

[9]The Ambetter by Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and Participating Pharmacies. Some drugs on the list may require Prior Authorization from Health Net. Drugs that are not listed on the list (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. Urgent requests from Physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted. For a copy of the Ambetter by Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Health Net will cover Brand Name Drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 Copayment, when determined to be Medically Necessary.

[10]Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring, for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Ambetter by Health Net Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered.

[11]The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family *Plan Contract and EOC* for details.

[12]The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

Ambetter HMO plans are offered by Health Net of California, Inc. (Health Net). Health Net of California, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Plan Overview – Silver 70 Off Exchange Ambetter HMO

The Silver 70 Off Exchange **Ambetter HMO** health plan utilizes the **Ambetter HMO** provider network for Covered Benefits. Ambetter HMO is available directly through Health Net in Imperial, Los Angeles, Orange and San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC)* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible[1]	$4,700 single/$9,400 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$11,650 single/$23,300 family
Professional services Office visit copay[2]	$50
Telehealth consultation through the select telehealth services provider[3]	$0
Specialist visit[2]	$100
Other practitioner office visit (including medically necessary acupuncture)[4]	$50
Preventive care services[2,5]	$0
X-ray and diagnostic imaging	$95
Laboratory tests	$50
Imaging (CT, PET scans, MRIs)	$325
Rehabilitation and habilitation therapy	$50
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	30%
Hospital services Inpatient hospital stay (includes maternity)	Facility: 30% after deductible; Physician: 30%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30% after deductible
Emergency services Emergency room services (copay waived if admitted)	Facility: $400; Physician: $0
Urgent care	$50
Ambulance services (ground and air)	$255
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 30% after deductible; Physician: 30%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $50 Other than office visit: $0
Home health care services (100 visits per calendar year)	$45
Other services Durable medical equipment	20%
Hospice service	$0
Prescription drug coverage[7,8,9,10,11] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	$50 single / $100 family
Tier 1 (most generics and low-cost preferred brand)	$20

Benefit description	Member(s) responsibility
Tier 2 (non-preferred generics and preferred brand)	$65 after RX Deductible
Tier 3 (non-preferred brand)	$95 after RX Deductible
Tier 4 (Specialty drugs)[12]	20% up to $250/script after Rx Deductible
Pediatric dental[13] Diagnostic and preventive services	$0
Pediatric vision[14] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

[1] For certain services and supplies under this Plan, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the Covered Expenses exceed the Deductible. The Calendar Year Deductible applies, unless specifically noted above.

[2] Prenatal, postnatal and newborn care office visits for Preventive Care Services, including preconception visits, are covered in full. See Copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other non-preventive services are received during the same office visit, a Copayment will apply for the non-preventive services.

[3] You may receive services on an in-person basis or via telehealth, if available, from your Primary Care Physician, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your Plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your Primary Care Physician.

[4] Includes acupuncture visits, physical, occupational and speech therapy visits, and other office visits not provided by either Primary Care Physician or specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture Services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

[5] Preventive care services are covered for children and adults, as directed by your Physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[6] For hospitals that do not separate charges for inpatient facility and inpatient professional services, the inpatient facility fee applies.

[7] Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

[8] If the pharmacy's cost of the prescription is less than the applicable Copayment, then you will only pay the pharmacy's cost of the prescription.

[9] The Prescription Drug Deductible (per Calendar Year) must be paid before Health Net begins to pay. If you are a Member in a family of two or more members, you reach the Prescription Drug Deductible either when you meet the amount for any one Member, or when your entire family reaches the family amount.

The Prescription Drug Deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a Participating Pharmacy and preventive drugs and contraceptives. Prescription drug Covered Expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription for covered Prescription Drugs.

[10] Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a brand-name preventive drug or contraceptive is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the Prescription Drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a Physician) under the medical benefit.

[11] The Ambetter from Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and Participating Pharmacies. Some drugs on the list may require Prior Authorization from Health Net. Drugs that are not listed on the list (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. Urgent requests from Physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted. For a copy of the Ambetter from Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Health Net will cover Brand Name Drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 Copayment, when determined to be Medically Necessary.

[12] Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring, for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Ambetter from Health Net Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered.

[13] The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family *Plan Contract and EOC* for details.

[14] The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

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Plan Overview – Bronze 60 Ambetter HMO

The Bronze 60 Ambetter HMO health plan utilizes the **Ambetter HMO** provider network for Covered Benefits. **Ambetter HMO** is available through Covered California in Imperial County and parts of Kern County.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC)* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible (also applies to prescription drugs)[1]	$5,800 single/$11,600 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$11,650 single/$23,300 family
Professional services Office visit copay[2]	$60
Telehealth consultation through the select telehealth services provider[4]	$0
Specialist visit[2]	Visits 1-3: $100[3]/ Visits 4+: $100 after deductible
Other practitioner office visit (including medically necessary acupuncture)[5]	$60
Preventive care services[2,6]	$0
X-ray and diagnostic imaging	40% after deductible
Laboratory tests	$50
Imaging (CT, PET scans, MRIs)	40% after deductible
Rehabilitation and habilitation services	$60
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	40% after deductible
Hospital services Inpatient hospital stay (includes maternity)	40% after deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	40% after deductible
Emergency services Emergency room services (copayment waived if admitted)	Facility: 40% after deductible Physician: $0
Urgent care	$60
Ambulance services (ground and air)	40% after deductible
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	40% after deductible
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $60 Other than office visit: 40% up to $60
Home health care services (100 visits per calendar year)	40% after deductible
Other services Durable medical equipment	40% after deductible
Hospice service	$0
Prescription drug coverage[7,8,9,10] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	$450 single/$900 family
Tier 1 (most generics and low-cost preferred brand)	$20

Benefit description	Member(s) responsibility
Tier 2 (non-preferred generics and preferred brand)	40% up to $500/script after Rx Deductible
Tier 3 (non-preferred brand)	40% up to $500/script after Rx Deductible
Tier 4 (Specialty drugs)[11]	40% up to $500/script (after Rx Deductible)
Pediatric dental[12] Diagnostic and preventive services	$0
Pediatric vision[13] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

[1]For certain services and supplies under this Plan, including Prescription Drugs and pediatric dental services, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the Covered Expenses exceed the Deductible. The Calendar Year Deductible applies, unless specifically noted above.

[2]Prenatal, postnatal and newborn care office visits for Preventive Care Services, including preconception visits, are covered in full. See Copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other non-preventive services are received during the same office visit, a Copayment will apply for the non-preventive services.

[3]The Calendar Year Deductible applies after the first 3 non-preventive visits. Non-preventive visits include urgent care visits, office visits to a Physician, Physician Assistant, Nurse Practitioner, other practitioner or postnatal office visits and Mental Health or Substance Use Disorder outpatient visits.

[4]YYou may receive services on an in-person basis or via telehealth, if available, from your Primary Care Physician, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your Plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your Primary Care Physician.

[5]Includes acupuncture visits, physical, occupational and speech therapy visits, and other office visits not provided by either Primary Care Physician or specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture Services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

[6]Preventive care services are covered for children and adults, as directed by your Physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[7]Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

[8]If the pharmacy's cost of the prescription is less than the applicable Copayment, then you will only pay the pharmacy's cost of the prescription.

[9]Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member, and are not subject to the Deductible. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a brand-name preventive drug or contraceptive is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the Prescription Drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a Physician) under the medical benefit.

[10]The Ambetter from Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and Participating Pharmacies. Some drugs on the list may require Prior Authorization from Health Net. Drugs that are not listed on the list (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. Urgent requests from Physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted. For a copy of the Ambetter from Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Health Net will cover Brand Name Drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 Copayment, when determined to be Medically Necessary.

[11]Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring, for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Ambetter from Health Net Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered.

[12]The pediatric dental benefits are provided by Health Net of California, Inc., and administered by Dental Benefit Providers of California, Inc., (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family *Plan Contract and EOC* for details.

[13]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

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Health Net of California Inc. (Health Net)

California Individual & Family Plans
Available directly through Health Net

Plan Overview – Minimum Coverage Ambetter HMO

The Minimum Coverage Ambetter HMO health Plan utilizes the **Ambetter HMO** provider network for Covered Benefits. **Ambetter HMO** is available through Covered California in Imperial County and parts of Kern County.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC)* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The Copayment amounts listed below are the fees charged to you for Covered Benefits you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar Copayments are due and payable at the time services are rendered. Percentage Copayments are usually billed after the service is received. Covered Benefits for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Benefits delivered in-person.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible (also applies to prescription drugs)[1]	$12,000 single/$24,000 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$12,000 single/$24,000 family
Professional services Office visit copay[2]	Visits 1–3: 0%[3] Visits 4:+ 0% after deductible
Telehealth consultation through the select telehealth services provider[4]	$0
Specialist visit[2]	0% after deductible
Other practitioner office visit (including medically necessary acupuncture)[5]	Visits 1–3: 0%[3] Visits 4:+ 0% after deductible
Preventive care services[2,6]	$0
X-ray and diagnostic imaging	0% after deductible
Laboratory tests	0% after deductible
Imaging (CT, PET scans, MRIs)	0% after deductible
Rehabilitation and habilitation services	0% after deductible
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	0% after Deductible
Hospital services Inpatient hospital stay (includes maternity)	0% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0% after Deductible
Emergency services Emergency room services (copayment waived if admitted)	Facility: 0% after deductible Physician: $0
Urgent care	Visits 1–3: 0%[3] Visits 4:+ 0% after deductible
Ambulance services (ground and air)	0% after deductible
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	0% after deductible
Mental/Behavioral health/substance use disorder (outpatient)	Office visits 1-3: 0% [3] Office visits 4+: 0% after deductible Other than office visit: 0% after deductible
Home health care services (100 visits per calendar year)	0% after deductible
Other services Durable medical equipment	0% after deductible
Hospice service	0% after deductible
Prescription drug coverage[7,8,9,10] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	Integrated with medical deductible

Benefit description	Member(s) responsibility
Tier 1 (most generics and low-cost preferred brand)	0% after medical deductible
Tier 2 (non-preferred generics and preferred brand)	0% after medical deductible
Tier 3 (non-preferred brand)	0% after medical deductible
Specialty drugs[11]	0% after medical deductible
Pediatric dental[12] Diagnostic and preventive services	$0
Pediatric vision[13] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

[1]For certain services and supplies under this Plan, including Prescription Drugs and pediatric dental services, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the Covered Expenses exceed the Deductible. The Calendar Year Deductible applies, unless specifically noted above.

[2]Prenatal, postnatal and newborn care office visits for Preventive Care Services, including preconception visits, are covered in full. See Copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other non-preventive services are received during the same office visit, a Copayment will apply for the non-preventive services.

[3]The Calendar Year Deductible applies after the first 3 non-preventive visits. Non-preventive visits include urgent care visits, office visits to a Physician, Physician Assistant, Nurse Practitioner, other practitioner or postnatal office visits and Mental Health or Substance Use Disorder outpatient visits.

[4]YYou may receive services on an in-person basis or via telehealth, if available, from your Primary Care Physician, a treating Specialist or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards required under California law. Any cost share for services received through the Select Telehealth Services Provider will accrue toward your out-of-pocket maximum and Deductible (if your Plan has a Deductible). By scheduling through the Select Telehealth Services Provider, you consent to receive services via telehealth through the Select Telehealth Services Provider. See the Individual & Family *Plan Contract and EOC* for coverage information and for the definition of Telehealth Services. You have a right to access your medical records for services received through the Select Telehealth Services Provider. Unless you choose otherwise, any services provided through the Select Telehealth Services Provider shall be shared with your Primary Care Physician.

[5]Includes acupuncture visits, physical, occupational and speech therapy visits, and other office visits not provided by either Primary Care Physician or specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture Services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

[6]Preventive care services are covered for children and adults, as directed by your Physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) 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). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including Preventive Care Services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

[7]Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

[8]If the pharmacy's cost of the prescription is less than the applicable Copayment, then you will only pay the pharmacy's cost of the prescription.

[9]Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member, and are not subject to the Deductible. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a brand-name preventive drug or contraceptive is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the Prescription Drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a Physician) under the medical benefit.

[10]The Ambetter from Health Net Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted Physicians and Participating Pharmacies. Some drugs on the list may require Prior Authorization from Health Net. Drugs that are not listed on the list (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require Prior Authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 Copayment if the Member's Physician demonstrates medical necessity. Urgent requests from Physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted. For a copy of the Ambetter from Health Net Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Health Net will cover Brand Name Drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 Copayment, when determined to be Medically Necessary.

[11]Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring, for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Ambetter from Health Net Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered.

[12]The pediatric dental benefits are provided by Health Net of California, Inc., and administered by Dental Benefit Providers of California, Inc., (DBP). DBP is a California licensed specialized dental Plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family *Plan Contract and EOC* for details.

[13]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

Ambetter from Health Net HMO plans are offered by Health Net of California, Inc. Health Net of California, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. Covered California is a registered trademark of the State of California. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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How to apply

To apply for medical, dental or vision coverage with Health Net :

- Call **1-800-909-3447;** or
- Contact your Health Net authorized agent.

If you are completing a paper application:

- Make sure you choose a Primary Care Physician. Finding a PCP is easy with Health Net's doctor search. To find the most up-to-date list, log on to www.myhealthnetca.com > Find a Provider. You'll find a complete listing of our Individual & Family Plan network Physicians, and you can search specialty, city, county or doctor's name. You can also call **1-800-909-3447** to request provider information or contact your Health Net authorized broker.
- Sign and date the application. (Each person over the age of 18 listed on the application must sign and date the application.)
- Include a check payable to Health Net for the applicable premium payment.
- Mail the completed application and check (within 30 days of signature date) to your authorized Health Net agent or to:

  Health Net
  Individual & Family Coverage
  P.O. Box 989731
  West Sacramento, CA
  95798-9731

Important Things To Know About Your Medical Coverage

Who is eligible?

To be eligible for a Health Net Ambetter Individual & Family Plan, you must: (a) live in the Service Area for an Ambetter HMO Plan; and (b) apply for enrollment during an open enrollment period or during a special enrollment period as defined below. In addition, the following are eligible to enroll as dependents: (1) your spouse or Domestic Partner (see below for definition), if under age 65; (2) your children to age 26; and (3) a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Service Area. The following persons are not eligible for coverage under this Plan: (a) persons eligible for enrollment in a group Plan with minimum essential coverage; (b) persons age 65 and older and eligible for Medicare benefits (except for Dependent parents/stepparents as described above); (c) persons who are incarcerated; and (c) persons eligible for Medi-Cal, Healthy Families or other applicable state or federal programs.

For 2027, enrollment takes place November 1, 2026 to January 31, 2027 inclusive.

NOTE: Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with permanent kidney failure. If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications. You can get free counseling regarding your Medicare eligibility and enrollment options by calling the Health Insurance Counseling and Advocacy Program (HICAP) at **1-800 434-0222.** Visit http://www.cahealthadvocates.org/hicap to find a HICAP office near you.

Special Enrollment Periods

In addition to the open enrollment period, you are eligible to enroll in this Plan within 60 days of certain events, including, but not limited to the following:

- Gained, lost or changed Dependent status due to marriage, domestic partnership, divorce, legal separation, dissolution of domestic partnership, birth, adoption, placement for adoption, coverage mandated by a valid state or federal court order, or assumption of a parent/stepparent-child relationship;
- Were mandated to be covered as a Dependent due to a valid state or federal court order;
- Were released from incarceration;

- Demonstrate that you had a material provision of your health coverage contract substantially violated by your health coverage issuer;
- Gained access to new health benefit plans as a result of a permanent move;
- Were receiving services under another health benefit Plan from a contracting provider who is no longer participates in that health Plan for any of the following conditions: (a) an acute or serious condition; (b) a Terminal Illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contracts termination date or the Effective Date of coverage for a newly covered Member;
- Demonstrate to Covered California that you did not enroll in a health benefit Plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage;
- Are a Member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code;
- Were not allowed to enroll in a Plan through Covered California due to the intentional, inadvertent or erroneous actions of the Exchange.
- Are a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
- Apply for coverage through Covered California during the annual open enrollment period or due to a qualifying event and are assessed by Covered California as potentially eligible for Medi-Cal and are determined ineligible for such coverage either after open enrollment has ended or more than 60 days after the qualifying event.
- Apply for coverage with Medi-Cal during the annual open enrollment period and are determined ineligible for such coverage after open enrollment has ended.
- Adequately demonstrate to Covered California that a material error related to Plan benefits, Service Area or premium influenced your decision to purchase coverage through Covered California.
- Gain access to the Individual Coverage Health Reimbursement Arrangement (ICHRA) and are not already covered by the ICHRA.

For the following, you are eligible to enroll 60 days before and 60 days after the event:

- Lost coverage in a Plan with minimum essential coverage (coverage becomes effective the first of the following month after loss of coverage), not including voluntary termination, loss due to non-payment of premiums or situations allowing for a rescission (fraud or intentional misrepresentation of material fact);
- Lost medically needy coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Lost pregnancy-related coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the COBRA continuation coverage or government subsidies completely ceased.

Domestic Partner

Domestic partner is the Subscriber's partner if the Subscriber and partner are a couple who are registered Domestic Partners that meet all the requirements of Section 297or 299.2 of the California Family Code.

How does the monthly billing work?

Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases or changes in benefits or Plan Contract provisions after the enrollment Effective Date, you will be notified at least 60 days in advance.

Health Net will provide Subscribers with at least 60 days' notice of any changes in benefits, subscription charges or Plan Contract provisions. There is no vested right to receive the benefits of this health Plan.

Can benefits be terminated?

You may terminate your coverage at any time by notifying Health Net. In such event, termination will be effective on the first day of the month following Health Net's receipt of your request to terminate. Health Net has the right to terminate your coverage individually for any of the following reasons:

- You do not pay your premium on time (Health Net will issue a 30-day prior notice of our right to terminate your coverage for non-payment of premium. The 30-day prior notice will be sent on or before the first day of the month for which premiums are due and will describe the 30-day grace period, which grace period begins after the last day of paid coverage. If you do not pay your premiums by the first day of the month for which premiums are due, Health Net can terminate your coverage after the 30-day grace period.).
- You and/or your Family Member(s) cease being eligible (see "Who is Eligible?" section)
- You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include misrepresenting eligibility information about you or a Dependent; presenting an invalid prescription or Physician order; or misusing a Health Net Member ID card (or letting someone else use it).

Health Net can terminate your coverage, together with all like policies, by giving 90 day's written notice. Members are responsible for payment of any services received after termination of coverage at the provider's prevailing non-member rates. This is also applicable to Members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage.

If you terminate coverage for yourself or any of your Family Members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

Can coverage be rescinded or canceled for fraud or intentional misrepresentation of material fact?

When Health Net can rescind or cancel a plan contract:

Within the first 24 months of coverage Health Net may rescind the *Plan Contract* for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

Health Net may cancel a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the Plan Contract.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

Cancellation of a Plan Contract

If this *Plan Contract* is canceled, you will be sent a notice of cancelation 30 days prior to the Effective Date of the cancellation.

Rescission of a Plan Contract

If the *Plan Contract* is rescinded, Health Net shall have no liability for the provision of coverage under the *Plan Contract*.

By signing the enrollment application, you represent that all responses are true, complete and accurate, to the best of your knowledge, and that should Health Net accept your enrollment application, the enrollment application will become part of the *Plan Contract* between Health Net and you. By signing the enrollment application, you further agree to comply with the terms of the *Plan Contract*.

If after enrollment Health Net investigates your enrollment application information, Health Net must notify you of this investigation, the basis of the investigation and offer you an opportunity to respond.

If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net.

If the *Plan Contrac*t is rescinded, Health Net will provide a 30-day written notice prior to the Effective Date of the termination that will:

1. explain the basis of the decision;
2. provide the Effective Date of the rescission;
3. clarify that all Members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
4. explain that your monthly premium will be modified to reflect the number of Members that remain under the Plan Contract;
5. explain your right and the options you have of going to both Health Net and/or the Department of Managed Health Care if you do not agree with Health Net's decision.
6. Include a Right to Request Review form. You have 180 days from the date of the Notice of Cancellation, Rescission or Nonrenewal to submit the Right to Request Review form to Health Net and/or the Department of Managed Health Care.

If the *Plan Contract* is rescinded:

1. Health Net may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recover from you any amounts paid under the *Plan Contract* from the original date of coverage; and
3. Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

Are there any renewal provisions?

Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 60 days in advance of any changes in fees, benefits or contract provisions.

Does Health Net coordinate benefits?

Health Net will coordinate benefits for our Members with pediatric dental benefits covered under this Plan. There is no coordination of benefits for medical services in the Individual market.

What is utilization review?

Health Net makes medical care covered under our Individual & Family Plans subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care. Health Net bases the approval or denial of services on the following main procedures:

- Evaluation of medical services to assess medical necessity and appropriate level of care
- Implementation of case management for long-term or chronic conditions
- Review and authorization of inpatient admission and referrals to noncontracting providers
- Review of scope of benefits to determine coverage

If you would like additional information regarding Health Net's Utilization Review System, please call the Health Net's Customer Contact Center at **1-800-839-2172.**

Does Health Net cover the cost of participation in Approved Clinical Trials?

Routine patient care costs for items and services furnished in connection with participating in an Approved Clinical Trial are covered when Medically Necessary, authorized by Health Net, and either the Member's treating Physician has recommended participation in the trial or the Member has provided medical and scientific information establishing eligibility for the Approved Clinical Trial. For further information, please refer to the *Plan Contract and Evidence of Coverage*.

What if I have a disagreement with Health Net ?

Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, or subject to or received an adverse benefit determination may file a grievance or appeal. An adverse benefit determination includes: (a) rescission of coverage, even if it does not have an adverse effect on a particular benefit at the time; (b) determination of an individual's eligibility to participate in this Health Net Plan; (c) determination that a benefit is not covered; (d) an exclusion or limitation of an otherwise Covered Benefit based on a pre-existing condition exclusion or a source of injury exclusion; or, (e) determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate. In addition, Plan Members can request an Independent Medical Review (IMR) of disputed Health Care Services from the Department of Managed Health Care if they believe that Health Care Services eligible for coverage and payment under their Health Net Plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies a Member's appeal of a denial for lack of medical necessity or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, Members can request an Independent Medical Review (IMR) of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the *Plan Contract and Evidence of Coverage*.

Members not satisfied with the results of the appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. As a condition of enrollment, Members give up their right to a jury or trial before a judge for the resolution of such disputes.

The California Department of Managed Health Care is responsible for regulating Health Care Service Plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-800-839-2172** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **1-888-466-2219** and a **TDD line 1-877 688-9891** for the hearing and speech impaired. The Department's internet web site **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?

With the Ambetter HMO Plan, Health Net Members have the right to request a second opinion when:

- The Member's PCP or a referral Physician gives a diagnosis or recommends a treatment Plan with which the Member is not satisfied;
- The Member is not satisfied with the result of treatment received;
- The Member is diagnosed with, or a treatment Plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including, but not limited to a Serious Chronic Condition, or
- The Member's PCP or a referral Physician is unable to diagnose the Member's condition, or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact the Health Net's Customer Contact Center at **1 800-522-0088.**

What are Health Net's premium ratios?

Health Net's 2025 ratio of premium costs to health services paid for Individual & Family HMO Plans was 82.0%.

What is the relationship of the involved parties?

Physician Groups, contracting Physicians, hospitals, participating providers, and other Health Care Providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or employees of any Physician Group, contract Physician, Hospital, or other Health Care Provider.

All of the parties are independent contractors and contract with each other to provide you with the Covered Benefits or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net, their agents, or employees, or of Physician Groups, participating providers, any Physician or Hospital, or any other person or organization with which Health Net has arranged or will arrange to provide the Covered Benefits and supplies of your Plan.

What about continuity of care upon termination of a provider contract?

If Health Net's contract with a Physician Group, participating provider or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or participating provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group, participating provider or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within five days after the Effective Date of the contract termination.

In addition, the Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination, unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

To request continued care for medical services, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Request Form or of our continuity of care policy, please contact Health Net's Customer Contact Center at the number on the back of your Health Net ID card or visit our website at **www.myhealthnetca.com.**

If you need continued care for Mental Health or Substance Use Disorders, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under the Plan's *Plan Contract and Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at **1-800-522-0088** to ensure that you can obtain the Health Care Services that you need.

What is the method of provider reimbursement?

Health Net uses financial incentives and various risk-sharing arrangements when paying providers. Members may request more information about our payment methods by contacting Health Net's Customer Contact Center at the telephone number on the back of their Health Net ID card.

When and how does Health Net pay my medical bills?

We will coordinate the payment for Covered Benefits when you receive care from a participating provider or your Primary Care Physician or, for the HMO Plans, when you are referred by your PCP to a Specialist. We have agreements with these Physicians that eliminate the need for claim forms. Simply present your Health Net Member ID card.

Am I required to see my Primary Care Physician or a participating provider if I have an emergency?

Health Net covers Emergency Services and Care and Urgently Needed Care throughout the world.

In serious emergency situations: Call "911" or go to the nearest Hospital.

If your situation is not so severe: HMO Plan Members should call their Primary Care Physician or Physician Group, or a Participating Mental Health Professional. You can also call 988, the national suicide and mental health crises hotline system.

If you are unable to call and you need medical or mental health care right away, go to the nearest medical center or Hospital.

Emergency care includes medical screening, examination, and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of their license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe Pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) Placing the patient's health in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part. Active labor means labor at the time that either of the following could reasonably be expected to occur: (a) there is inadequate time to effect safe transfer to another Hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the Member or their unborn child.

Emergency care will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of their license and privileges) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capacity of the facility or by transferring the Member to a psychiatric unit within a general acute Hospital or to an acute psychiatric Hospital as Medically Necessary.

All air and ground ambulance and ambulance transport services provided as a result of a 911 emergency response system request for assistance will be covered, if the request meets the criteria for Emergency Services and Care as described in the Plan Contract and EOC.

All Follow-Up Care after the emergency or urgency has passed and your condition is stable, must be provided or authorized by your Primary Care Physician or Physician Group, otherwise, it will not be covered by Health Net.

Am I liable for payment of certain services?

We are responsible for paying participating providers for Covered Benefits. Except for Copayments and Deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the Plan's Plan Contract and EOC; and (b) services not covered by the Individual & Family Plan. The Individual & Family Plans do not cover prepayment fees, Copayments, Deductibles, services and supplies not covered by the Individual & Family Plans, or non-emergency care rendered by a non-participating provider.

Can I be reimbursed for out-of-network claims?

Some non-participating providers will ask you to pay a bill at the time of service. If you have to pay a bill for Covered Benefits, submit a copy of the bill, evidence of its payment and the emergency room or urgent care center report to us for reimbursement within one year of the date the service was rendered. Coverage for services rendered by non-participating providers is limited to Emergency Services and Care and, when you are outside a 30-mile radius of your Physician Group, urgent care.

How does Health Net handle confidentiality and release of Member information?

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings. As part of the application or enrollment form, Health Net Members sign a routine consent to obtain or release their Medical Information. This consent is used by Health Net to ensure notification to and consent from Members for present and future routine needs for the use of personal health information.

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all Subscribers and Members under the Plan for the purpose of review, investigation or evaluation of an application, claim, appeals (including the release to an independent reviewer organization) or grievance, or for preventive health or health management purposes.

We will not release your medical records or other confidential information to anyone such as employers or insurance brokers, who is not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order, or subpoena. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our Members.

Privacy Practices

For a description of how protected health information about you may be used and disclosed and how you can get access to this information, please see the "Notice of Privacy Practices" in the Plan's Plan Contract.

We shall not disclose Medical Information related to Sensitive Services provided to a Protected Individual to the Subscriber or any Plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care.

How does Health Net deal with new technologies?

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices.

New technologies are considered Investigational Services or Experimental Services during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational Services or Experimental Services if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or Investigational Services or Experimental Services, following extensive review of medical research by appropriately specialized Physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or Investigational Services or Experimental Services status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an Independent Medical Review (IMR) of Health Net's decision from the Department of Managed Health Care.

Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the *Plan Contract and Evidence of Coverage* for additional details.

What are Health Net's Utilization Management processes?

Utilization management is an important component of health care management. Through the processes of Prior Authorization, concurrent and retrospective review, and care management, we evaluate the services provided to our Members to be sure they are Medically Necessary and appropriate for the setting and time. This oversight helps to maintain Health Net's high quality medical management standards.

Prior Authorization

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate that the procedure is Medically Necessary and planned for the appropriate setting (i.e., inpatient, ambulatory surgery, etc.).

Concurrent Review

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a Member's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

Discharge Planning

This component of the concurrent review process ensures that planning is done for a Member's safe discharge in conjunction with the Physician's discharge orders and to authorize post Hospital services when needed.

Retrospective Review

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where Prior Authorization was required but not obtained.

Care or Case Management

Nurse care managers provide assistance, education and guidance to Members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with Members and their Physicians and community resources.

Additional Product Information

Mental health or substance use disorders

When you need to see a Participating Mental Health Professional, contact the Health Net Customer Contact Center at the phone number on your Health Net ID card. Health Net will help you identify a Participating Mental Health Professional within the network, close to where you live, with whom you can make an appointment.

Certain services and supplies for Mental Health or Substance Use Disorders may require Prior Authorization by Health Net in order to be covered.

Please refer to the Individual & Family *Plan Contract and EOC* for a more complete description of Mental Health or Substance Use Disorder services and supplies, including those that require Prior Authorization by Health Net .

You have a right to receive timely and geographically accessible Mental Health or Substance Use Disorder (MH/SUD) services when you need them. If Health Net fails to arrange those services for you with an appropriate provider who is in the health Plan's network, the health Plan must cover and arrange needed services for you from an out-of-network provider.

If that happens, you do not have to pay anything other than your ordinary in-network cost sharing.

If you do not need the services urgently, your health Plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health Plan. If you urgently need the services, your health Plan must offer you an appointment within 48 hours of your request (if the health Plan does not require Prior Authorization for the appointment) or within 96 hours (if the health Plan does require Prior Authorization).

If your health Plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health Plan's network. To be covered by your health Plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the Plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services, you can: (1) call your health Plan at the telephone number on the back of your health Plan identification card; (2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or (3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

CVS minute clinic services

The CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which is designed to offer an alternative to a Physician's office visit for the unscheduled treatment of non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer certain Preventive Care Services and immunizations. They are not designed to be an alternative for Emergency Services and Care or the ongoing care provided by a Physician.

You do not need Prior Authorization or a referral from your Primary Care Physician or contracting Physician Group in order to obtain access to CVS MinuteClinic services. However, under the HMO Plans, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations. For more detailed information about CVS MinuteClinics, please refer to the Health Net Individual & Family *Plan Contract and Evidence of Coverage* or contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card.

Telehealth consultations through the select telehealth services provider

Health Net contracts with certain Select Telehealth Services Providers to provide Telehealth Services for medical, Mental Health or Substance Use Disorder conditions. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card.

To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card. Services from the Select Telehealth Services Provider are not intended to replace services from your Physician, but are a supplemental service that may provide telehealth coverage for certain services at a lower cost. You are not required to use the Health Net selected Telehealth Services provider for Telehealth Services.

Telehealth consultations through the Select Telehealth Services Provider are confidential consultations by telephone or secure online video. The Select Telehealth Services Provider provides primary care services and may be used when your Physician's office is closed or you need quick access to a Physician. You do not need to contact your Primary Care Physician prior to using telehealth consultation services through the Select Telehealth Services Provider.

Prescription drug program

Health Net is contracted with many major pharmacies including, supermarket-based pharmacies and privately owned pharmacies in California. Please visit our website at www.myhealthnetca.com to find a conveniently located Participating Pharmacy, or call Health Net's Customer Contact Center at **1-800-522-0088.**

Specific exclusions and limitations apply to the Prescription Drug Program. See the Health Net Individual & Family *Plan Contract and Evidence of Coverage* for complete details. Remember, limits on quantity, dosage and treatment duration may apply to some drugs.

Maintenance Prescriptions By Mail Order Drug Program

If your prescription is for a Maintenance Drug, you have the option of filling it through our convenient mail order program.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to drug treatment. The mail order administrator may only dispense up to a 90-consecutive-calendar-day supply of a covered Maintenance Drug and each refill allowed by that order. Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefits. You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at **1-800-522-0088** or contact us at **www.myhealthnetca.com.**

Note: Schedule II narcotic drugs are not covered through mail order. See the Health Net Individual & Family *Plan Contact and EOC* for additional information.

The Ambetter by Health Net Drug List: Tier 1 drugs (most Generic Drugs and low-cost preferred Brand Name Drugs) and Tier 2 Drugs (non-preferred Brand Name Drugs, preferred Brand Name Drugs and drugs recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost).

The Ambetter by Health Net Drug List (or Formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net participating providers, contracting Primary Care Physicians and Specialists that they refer to this list when choosing drugs for patients who are Health Net Members. When your Physician prescribes medications listed in the Ambetter by Health Net Drug List, it ensures that you are receiving a high-quality prescription medication that is also of high value.

The Ambetter by Health Net Drug List is updated regularly, based on input from the Pharmacy and Therapeutics (P&T) Committee. This committee's members are actively practicing Physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Ambetter by Health Net Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the list current, the P&T Committee evaluates clinical effectiveness, safety, and overall value through:

- Medical and scientific publications
- Relevant utilization experience
- Physician recommendations

To obtain a copy of Health Net's most current Ambetter by Health Net Drug List, please visit our web site at **www.myhealthnetca.com**, or call Health Net's Customer Contact Center at **1-800-522-0088.** You can search the Ambetter by Health Net Drug List to determine whether or not a particular drug is covered.

Tier 3 Drugs

Tier 3 Drugs consists of non-preferred Brand Name Drugs or drugs that are recommended by the Health Care Service Plan's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 Drugs (Specialty Drugs)

Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost the health Plan more than six hundred dollars ($600) net of rebates for a one-month supply. Tier 4 Drugs (Specialty Drugs) are identified in the Ambetter by Health Net Drug List with "SP." Refer to the Ambetter by Health Net Drug List on our website at www.myhealthnetca.com for the Specialty Drugs listing.

All Tier 4 Drugs (Specialty Drugs) require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 Drugs (Specialty Drugs) are not available through mail order.

Self-injectable drugs (other than insulin), including drugs for the treatment of hemophilia, and needles and syringes used with these self-injectable drugs are included under Tier 4 Drugs (Specialty Drugs), which are subject to Prior Authorization and must be obtained through Health Net's contracted specialty pharmacy vendor. Your PCP or treating Physician will coordinate the authorization and upon approval the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor may contact you directly to coordinate the delivery of your medications.

Step Therapy

Step therapy is a process in which you may need to use one type of Prescription Drug before Health Net will cover another one. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. Exceptions to the step therapy process are subject to Prior Authorization. However, if you were taking a Prescription Drug for a medical condition under a previous Plan before enrolling in this HMO Plan, you will not be required to use the step therapy process to continue using the Prescription Drug.

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the Prescription Drug prescribed by a Health Care Provider for a Member. For more information on the step therapy exception process, please see "Step Therapy Exception" in the Ambetter by Health Net Drug List on **www.myhealthnetca.com.**

If an exception request is approved, drugs will be covered, including refills, as shown in the "Schedule of Benefits and Copayments" section of your Plan Contract and EOC. If an exception is denied, the drug is not covered, and you are responsible for the entire cost of the drug.

What is "Prior Authorization"?

Some Tier 1, Tier 2 and Tier 3 prescription medications require Prior Authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Upon receiving your Physician's request for Prior Authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. You may obtain a list of drugs requiring Prior Authorization by visiting our website at www.myhealthnetca.com or contact the Health Net Customer Contact Center at the phone number on the back cover.

The criteria used for Prior Authorization are developed and based on input from the P&T Committee as well as Physician Specialist experts. Your Physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision. See "What if I have a disagreement with Health Net ?" earlier in this guide.

Prescription Drug Program Exclusions and Limitations

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your Plan. In addition to the exclusion and limitations listed below, Prescription Drug benefits are subject to the Plan's general exclusions and limitations. Consult the *Plan Contract and EOC* for more information.

- Allergy serum is covered as a medical benefit.
- Brand name drugs that have generic equivalents are not covered without Prior Authorization from Health Net .
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers and diabetic supplies. No other devices are covered even if prescribed by a participating Physician.
- Drugs prescribed for the treatment of obesity are not covered, except when Medically Necessary for the treatment of severe obesity and when you meet Health Net Prior Authorization coverage requirements. The prescribing Physician must request and obtain Prior Authorization for coverage.
- Drugs prescribed to shorten the duration of the common cold.

- Experimental drugs (those that are labeled "Caution – Limited by federal law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to Independent Medical Review (IMR). See "What if I have a disagreement with Health Net " section of this brochure for additional information.
- Hypodermic needles or syringes, except for insulin needles, syringes, and specific brands of pen devices and pen needles.
- Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are covered only when Medically Necessary or when the medication is only available in that form.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.
- Some drugs are subject to specific quantity limitations per Copayment based on recommendations for use by the FDA or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net .
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a Physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force (USPSTF) A and B recommendations or for contraception as approved by the FDA. Any other non-Prescription Drug, medical equipment or supply that can be purchased without a Prescription Drug Order is not covered even if a Physician writes a Prescription Drug Order for such drug, equipment or supply. However, if a higher dosage form of a Prescription Drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug may be covered if Medically Necessary.
- Prescription drugs filled at pharmacies that are not in the Health Net Ambetter Pharmacy Network are not covered except in emergency or urgent care situations.
- Prescription drugs prescribed by a Physician who is not a Member or participating Physician or an authorized Specialist are not covered, except when the Physician's services have been authorized, or because of a medical emergency condition, illness or injury, for Urgently Needed Care or as specifically stated.
- Replacement of lost, stolen or damaged medications.
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except when such drugs are considered Experimental Services or Investigational Services or part of treatment under an Approved Clinical Trial. For additional guidance, see "Does Health Net cover the cost of participation in Approved Clinical Trials?" and "What if I have a disagreement with Health Net ?" earlier in this guide.
- Drugs prescribed for a condition or treatment not covered by this Plan are not covered. However, the Plan does cover Medically Necessary drugs for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as Life-Threatening complications of cosmetic surgery).
- Drugs (including injectable medications) when Medically Necessary and on the Ambetter by Health Net Drug List for treating sexual dysfunction are limited to a maximum of 8 doses in any 30-day period.
- Prescription drugs prescribed to a Surrogate, including a Member and/or Family Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member and/or Family Member, and any child born as a result of a Surrogacy Arrangement.

This is only a summary. For a comprehensive listing, see the Health Net Individual & Family Exchange *Plan Contract and EOC*.

Acupuncture Care Program

Acupuncture Services, typically provided only for the treatment of nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain, are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a Contracted Acupuncturist from the ASH Plans Contracted Acupuncturist Directory.

ASH Plans will arrange covered Acupuncture Services for you. You may access any Contracted Acupuncturist without a referral from a participating provider, Physician or your PCP.

You may receive covered Acupuncture Services from any Contracted Acupuncturist, and you are not required to pre-designate a Contracted Acupuncturist prior to your visit from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from a Contracted Acupuncturist except that:

- If covered Acupuncture Services are not available and accessible to you in the county in which you live, you may obtain covered Acupuncture Services from a non-contracted acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH Plans.
  - All covered Acupuncture Services may be subject to verification of medical necessity by ASH Plans except:
- A new patient examination by a Contracted Acupuncturist and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Acupuncture Services, to the extent consistent with professionally recognized standards of practice.

Acupuncture Care Program Exclusions and Limitations

Services or supplies excluded under the acupuncture care program may be covered under the medical benefits portion of your Plan. Consult the Plan's Plan Contract and EOC for more information.

- Auxiliary aids and services are not covered.
- Services provided by an acupuncturist practicing outside California are not covered.
- Diagnostic radiology, including MRIs or thermography are not covered;
- X-rays, laboratory tests, and x-ray second opinions;
- Hypnotherapy, behavioral training, sleep therapy and weight programs are not covered;
- Educational programs, non-medical self-care, self-help training and related diagnostic testing are not covered;
- Experimental or investigational Acupuncture Services are not covered.
- Charges for Hospital confinement and related services are not covered;
- Charges for anesthesia are not covered;
- Services or treatment rendered by acupuncturists who do not contract with ASH Plans are not covered;
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered.

This is only a summary. For a comprehensive listing, see the Health Net Individual & Family *Plan Contract and EOC*.

Pediatric vision care program

Eyewear benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to provide and administer eyewear benefits. EyeMed Vision Care, LLC provides benefits for eyewear through a network of dispensing opticians and optometric laboratories. Vision examinations are provided through your participating provider or Physician Group, or you may schedule a vision examination through EyeMed Vision Care, LLC. To find a participating eyewear dispenser, call the Health Net Vision Program at **1-866-392-6058** or visit our website at **www.myhealthnetca.com.**

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

Pediatric Vision Care Program Exclusions and Limitations

Services or supplies excluded under the vision care program may be covered under the medical benefits portion of your Plan. Consult the Plan's *Plan Contract and EOC* for more information.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

The following items are excluded when obtained while receiving pediatric vision services:

- Services and supplies provided by a provider who is not a Participating Vision Provider are not covered.
- Charges for services and materials that Health Net determines to be non-Medically Necessary are excluded. One routine eye exam with dilation is covered every Calendar Year and is not subject to medical necessity.
- Plano (non-prescription) lenses are excluded.
- Coverage for prescriptions for contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames.
- Hospital and medical charges of any kind, vision services rendered in a Hospital and medical or surgical treatment of the eyes, are not covered.
- Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this Plan.
- A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

This is only a summary. For a comprehensive listing, see the Health Net Individual & Family P*lan Contract and EOC*.

Professional services	Copayment
Routine eye examination with dilation	$0[1]
Examination for contact lenses Standard contact lens fit and follow-up	$0[1]
Premium contact lens fit and follow-up	$0[1]
Limitation: [1]In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every Calendar Year. **Note:** Examination for contact lenses is in addition to the Member's vision examination. There is no additional Copayment for contact lens follow-up visit after the initial fitting exam. Benefits may not be combined with any discounts, promotional offerings or other group benefit Plans. Allowances are one time use benefits. No remaining balance. Standard contact lenses include soft, spherical and daily wear contact lenses. Premium contact lenses include toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable contact lenses.	
Materials (includes frames and lenses)	**Copayment**
Provider selected Frames (one every Calendar Year)	$0
Standard Eyeglass Lenses (one pair every Calendar Year) • Single vision, bifocal, trifocal, lenticular • Glass or plastic, including polycarbonate	$0
Optional lenses and treatments including: • UV treatment • Tint (fashion & gradient & glass-grey) • Standard plastic scratch coating • Photochromatic/transitions plastic • Standard and premium anti-reflective coating • Polarized • Standard and premium progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses	$0
Provider-selected contact lenses (in lieu of eyeglass lenses) • Standard (hard) contacts 1 contact per eye per every Calendar Year • Monthly contacts (six-month supply) • Bi-weekly (six-month supply) • Dailies (three-month supply) • Medically necessary[2]	$0
Subnormal or low vision services and aids – supplemental testing, Follow-Up Care, and low vision aids	$0
[2]Medically Necessary Contact Lenses: Contact lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism. Coverage of Medically Necessary contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses, lenses and frames.	

Pediatric Dental Services

Except as described below, all of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered.

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

If you have purchased a supplemental pediatric dental benefit Plan, pediatric dental benefits covered under this Plan will be paid first, with the supplemental pediatric dental benefit Plan covering non-Covered Benefits and or cost sharing as described in your supplemental pediatric dental benefit Plan coverage document.

IMPORTANT: If you opt to receive dental services that are not Covered Benefits under this Plan, a Participating Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a Covered Benefit, the dentist should provide the patient with a treatment Plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review your Plan's *Plan Contract and Evidence of Coverage*.

Administration of these pediatric dental Plan designs comply with requirements of the pediatric dental EHB benchmark Plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for pediatric dental services.

Note: For the HMO Minimum Coverage Plan, the pediatric dental Copayment listed below apply until the Calendar Year Deductible is met. Once the Calendar Year Deductible is met for the HMO Minimum Coverage Plan, your copay is $0 for the noted Covered Benefits for the remainder of the Calendar Year.

Selecting a dentist

Step 1: Go to www.yourdentalportal.com/healthnet.

Step 2: Scroll down and click on Find a Dentist under "Find Your Dentist" in the center screen.

Step 3: Select *Health Net DHMO CA ONLY* from the Select a Network drop-down list.

Step 4: Select whether to search for a dentist either by location, by dentist name or by practice name.

Step 5: Enter your search criteria; then click on Submit at the bottom of the page for the results of the search.

You may change your Primary Dentist once a month. Primary dentist changes made prior to the 15th of the month are effective the first of the following month.

Simply select a new dentist from the listing of Primary Dentists and call Health Net Dental's Customer Contact Center at **1-866-249-2382** with your change.

Specialist Referrals

During the course of treatment, you may require the services of a Specialist. Your selected Primary Dentist will submit all required documentation to us and we will advise you of the name, address, and telephone number of the Specialist who will provide the required treatment. These services are available only when the dental procedure cannot be performed by the selected Primary Dentist due to the severity of the problem.

Referrals to Specialists for Orthodontic Care

Each Member's Primary Dentist is responsible for the direction and coordination of the Member's complete dental care for benefits. If your Primary Dentist recommends orthodontic care and you wish to receive benefits for such care under this dental Plan, Health Net's Customer Contact Center will assist you in selecting a Participating Orthodontist from the Participating Orthodontist directory.

Medically Necessary Dental Services

Medically necessary dental services are dental benefits which are necessary and appropriate for treatment of a Member's teeth, gums and supporting structures according to professionally recognized standards of practice and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Emergency Dental

Emergency dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe Pain, or acute infection that a person could reasonably expect that immediate dental care is needed.

All selected general dentists provide Emergency Dental Care twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your selected general dentist. **If you require Emergency Dental Care, you may go to any dental provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior authorization for Emergency Dental Care is not required.**

Code	Service	Member Copayment
Diagnostic		
D0120	Periodic oral evaluation – established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation – problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation – new or established patient	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Charge
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12-month period	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient	No Charge
D0210	X-rays intraoral – comprehensive series (including bitewings) limited to once per provider every 36 months	No Charge
D0220	X-rays intraoral – periapical first film limited to a maximum of 20 periapical in a 12-month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapical taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical in a 12-month period.	No Charge
D0230	X-rays intraoral – periapical each additional film limited to a maximum of 20 periapical in a 12-month period	No Charge
D0240	X-rays intraoral – occlusal film limited to 2 in a 6-month period	No Charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector – first film	No Charge
D0251	Extraoral posterior dental radiographic image	No Charge
D0270	X-rays bitewing – single film limited to once per date of service	No Charge
D0272	X-rays bitewings – two films limited to once every 6 months	No Charge
D0273	X-rays bitewings – three films	No Charge
D0274	X-rays bitewings – four films – limited to once every 6 months	No Charge
D0277	Vertical bitewings – 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No Charge
D0322	Tomographic survey limited to twice in a 12-month period	No Charge
D0330	Panoramic film limited to once in a 36-month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)	No Charge
D0340	2D cephalometric radiographic image limited to twice in a 12-month period per provider	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0396	3D printing of a 3D dental surface scan	No Charge
D0460	Pulp vitality tests	No Charge

(continued)

Code	Service	Member Copayment
Diagnostic (continued)		
D0470	Diagnostic casts[NH1.1]	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0701	Panoramic radiographic image – image capture only	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No Charge
D0706	intraoral – occlusal radiographic image – image capture only	No Charge
D0707	intraoral – periapical radiographic image – image capture only	No Charge
D0708	intraoral – bitewing radiographic image – image capture only	No Charge
D0709	intraoral – comprehensive series of radiographic images – image capture only	No Charge
D0801	3D intraoral surface scan – direct	No Charge
D0802	3D dental surface scan – indirect	No Charge
D0803	3D facial surface scan – direct	No Charge
D0804	3D facial surface scan – indirect	No Charge
D0999	Office visit fee – per visit (Unspecified diagnostic procedure, by report)	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant – per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1353	Sealant repair – per tooth	No Charge
D1354	Interim caries arresting medicament application – per tooth	No Charge
D1355	Caries preventive medicament application – per tooth	No Charge
D1510	Space maintainer – fixed – unilateral limited to once per quadrant	No Charge
D1516	Space maintainer – fixed – bilateral, maxillary	No Charge
D1517	Space maintainer – fixed – bilateral, mandibular	No Charge
D1520	Space maintainer – removable – unilateral limited to once per quadrant	No Charge
D1526	Space maintainer – removable – bilateral, maxillary	No Charge
D1527	*Space maintainer – removable – bilateral, mandibular*	No Charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No Charge
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer – per quadrant	No Charge
D1557	Removal of fixed bilateral space maintainer – maxillary	No Charge
D1558	Removal of fixed bilateral space maintainer – mandibular	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral -- per quadrant	No Charge
Restorative		
D2140	Amalgam – one surface, primary limited to once in a 12-month period	$25
D2140	Amalgam – one surface, permanent limited to once in a 36-month period	$25
D2150	Amalgam – two surfaces, primary limited to once in a 12-month period	$30
D2150	Amalgam – two surfaces, permanent limited to once in a 36-month period	$30
D2160	Amalgam – three surfaces, primary limited to once in a 12-month period	$40
D2160	Amalgam – three surfaces, permanent limited to once in a 36-month period	$40
D2161	Amalgam – four or more surfaces, primary limited to once in a 12-month period	$45
D2161	Amalgam – four or more surfaces, permanent limited to once in a 36-month period	$45
D2330	Resin-based composite – one surface, anterior, primary limited to once in a 12-month period	$30
D2330	Resin-based composite – one surface, anterior, permanent limited to once in a 36-month period	$30

(continued)

Code	Service	Member Copayment
Restorative (continued)		
D2331	Resin-based composite – two surfaces, anterior primary limited to once in a 12-month period	$45
D2331	Resin-based composite – two surfaces, anterior permanent limited to once in a 36-month period	$45
D2332	Resin-based composite – three surfaces, anterior primary limited to once in a 12-month period	$55
D2332	Resin-based composite – three surfaces, anterior permanent limited to once in a 36-month period	$55
D2335	Resin-based composite – four or more surfaces(anterior) primary limited to once in a 12-month period	$60
D2335	Resin-based composite – four or more surfaces (anterior) permanent limited to once in a 36-month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12-month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36-month period	$50
D2391	Resin-based composite – one surface, posterior primary limited to once in a 12-month period	$30
D2391	Resin-based composite – one surface, posterior permanent limited to once in a 36-month period	$30
D2392	Resin-based composite – two surfaces, posterior; primary limited to once in a 12-month period	$40
D2392	Resin-based composite – two surfaces, posterior; permanent limited to once in a 36-month period	$40
D2393	Resin-based composite – three surfaces, posterior; primary limited to once in a 12-month period	$50
D2393	Resin-based composite – three surfaces, posterior; permanent limited to once in a 36-month period	$50
D2394	Resin-based composite – four or more surfaces, posterior; primary limited to once in a 12-month period	$70
D2394	Resin-based composite – four or more surfaces, posterior; permanent limited to once in a 36-month period	$70
D2710	Crown – resin-based composite (indirect) limited to once in a 5-year period	$140
D2712	Crown – ¾ resin-based composite (indirect) limited to once in a 5-year period	$190
D2721	Crown – resin with predominantly base metal limited to once in a 5-year period	$300
D2740	Crown – porcelain/ceramic limited to once in a 5-year period	$300
D2751	Crown – porcelain fused to predominantly base metal limited to once in a 5-year period	$300
D2781	Crown – ¾ cast predominantly base metal limited to once in a 5-year period	$300
D2783	Crown – ¾ porcelain/ceramic limited to once in a 5-year period	$310
D2791	Crown – full cast predominantly base metal limited to once in a 5-year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown – primary tooth limited to once in a 12-month period	$95
D2930	Prefabricated stainless steel crown – primary tooth limited to once in a 12-month period	$65
D2931	Prefabricated stainless steel crown – permanent tooth limited to once in a 36-month period	$75
D2932	Prefabricated resin crown, primary limited to once in a 12-month period	$75
D2932	Prefabricated resin crown, permanent limited to once in a 36-month period	$75
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12-month period	$80
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36-month period	$80
D2940	Placement of interim direct restoration limited to once per tooth in a 12-month period	$25
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention – per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post – same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post – same tooth	$35
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35
D2976	Band stabilization – per tooth	$40

(continued)

Code	Service	Member Copayment
Restorative (continued)		
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.	$50
D2989	Excavation of a tooth resulting in the determination of nonrestorability	$50
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No Charge
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) – anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; nonsurgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy – anterior	$240
D3347	Retreatment of previous root canal therapy – premolar	$295
D3348	Retreatment of previous root canal therapy – molar	$350
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	$85
D3352	Apexification/recalcification – interim medication replacement only following D3351. Limited to once per permanent tooth	$45
D3410	Apicoectomy – anterior	$240
D3421	Apicoectomy – premolar (first root)	$250
D3425	Apicoectomy – molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	$350
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	$350
D3430	Retrograde filling – per root	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80
D3471	Surgical repair of root resorption – anterior	$160
D3472	Surgical repair of root resorption – premolar	$160
D3473	Surgical repair of root resorption – molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$50
D4249	Clinical crown lengthening – hard tissue	$165

(continued)

Code	Service	Member Copayment
Periodontics (continued)		
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months	$265
D4261		
	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80
D4341	Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		
D5110	Complete denture – maxillary limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	$300
D5120	Complete denture – mandibular limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	$300
D5130	Immediate denture – maxillary	$300
D5140	Immediate denture – mandibular	$300
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$300
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$335
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5410	Adjust complete denture – maxillary limited to once per date of service; twice in a 12-month period	$20
D5411	Adjust complete denture – mandibular limited to once per date of service; twice in a 12-month period	$20
D5421	Adjust partial denture – maxillary limited to once per date of service; twice in a 12-month period	$20
D5422	Adjust partial denture – mandibular limited to once per date of service; twice in a 12-month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth – complete denture per tooth limited to a maximum of four, per arch, per date of service; twice per arch in a 12-month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials- per tooth – limited to a maximum of three, per date of service; twice per arch in a 12-month period	$50

(continued)

Code	Service	Member Copayment
Prosthodontics, removable (continued)		
D5640	Replace missing or broken teeth partial denture – per tooth – limited to maximum of four, per arch, per date of service; twice per arch in a 12-month period	$35
D5650	Add tooth to existing partial denture limited – per tooth – to a maximum of three, per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture – per tooth – limited to a maximum of three, per date of service; twice per arch in a 12-month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period	$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period	$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period	$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period	$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36-month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture – complete maxillary – natural tooth borne	$300
D5864	Overdenture – partial maxillary – natural tooth borne	$300
D5865	Overdenture – complete mandibular – natural tooth borne	$300
D5866	Overdenture – partial mandibular – natural tooth borne	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial Prosthetics		
D5909	Maxillary guidance prosthesis with guide flange	$350
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5930	Maxillary guidance prosthesis without guide flange	$350
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification limited to twice in a 12-month period	$150
D5934	Mandibular guidance prosthesis with guide flange	$350
D5935	Mandibular guidance prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85

(continued)

Code	Service	Member Copayment
Maxillofacial Prosthetics (continued)		
D5938	Resection prosthesis, maxillary complete removable	$350
D5939	Resection prosthesis, mandibular complete removable	$350
D5940	Resection prosthesis, maxillary partial removable	$350
D5941	Resection prosthesis, mandibular partial removable	$350
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	$350
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	$350
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	$350
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	$350
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	$350
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	$350
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	$350
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	$350
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12-month period	$145
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period	$145
D5982	Surgical stent for soft tissue healing	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Surgical access to an implant body (second stage implant surgery)	$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350
D6013	Surgical placement of mini-implant	$350
D6040	Surgical placement: eposteal implant	$350
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$35
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar – implant supported or abutment supported	$350
D6056	Prefabricated abutment – includes modification and placement	$135
D6057	Custom fabricated abutment – includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315

(continued)

Code	Service	Member Copayment
Implant Services (continued)		
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported crown (porcelain fused to high noble alloys)	$335
D6067	Implant supported crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown – porcelain fused to noble alloys	$335
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$335
D6085	Interim implant crown	$300
D6086	Implant supported crown – predominantly base alloys	$340
D6087	Implant supported crown – noble alloys	$340
D6088	Implant supported crown – titanium and titanium alloys	$340
D6089	Accessing and retorquing loose implant screw – per screw	$60
D6090	Repair of implant/abutment supported prosthesis	$65
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown – titanium and titanium alloys	$295
D6096	Removal of broken implant retaining screw	$60
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6105	Removal of implant body not requiring bone removal or flap elevation	$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	$350
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330

(continued)

Code	Service	Member Copayment
Implant Services (continued)		
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD – noble alloys	$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30
D6190	Radiographic/Surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	$265
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95
D6198	Remove interim implant component	$110
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, fixed		
D6211	Pontic – cast predominantly base metal limited to once in a 5-year period	$300
D6241	Pontic – porcelain fused to predominantly base metal limited to once in a 5-year period	$300
D6245	Pontic – porcelain/ceramic limited to once in a 5-year period	$300
D6251	Pontic – resin with predominantly base metal limited to once in a 5-year period	$300
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	$20
D6721	Retainer crown – resin predominantly base metal – denture limited to once in a 5-year period	$300
D6740	Retainer crown – porcelain/ceramic limited to once in a 5-year period	$300
D6751	Retainer crown – porcelain fused to predominantly base metal limited to once in a 5-year period	$300
D6781	Retainer crown – ¾ cast predominantly base metal limited to once in a 5-year period	$300
D6783	Retainer crown – ¾ porcelain/ceramic limited to once in a 5-year period	$300
D6784	Retainer crown – ¾ titanium and titanium alloys	$300
D6791	Retainer crown – full cast predominantly base metal limited to once in a 5-year period	$300
D6930	Recement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral Maxillofacial Prosthetics		
D7111	Extraction, coronal remnants – primary tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth – soft tissue	$95
D7230	Removal of impacted tooth – partially bony	$145
D7240	Removal of impacted tooth – completely bony	$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7252	Partial extraction for immediate implant placement	$80
D7259	Nerve dissection	$280
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7284	Excisional biopsy of minor salivary glands	$115
D7285	Incisional biopsy of oral tissue – hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	$180

(continued)

Code	Service	Member Copayment
Oral Maxillofacial Prosthetics (continued)		
D7286	Incisional biopsy of oral tissue – soft limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) limited to once in a 5-year period per arch	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7509	Marsupialization of odontogenic cyst	$180
D7510	Incision and drainage of abscess – intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess – extraoral soft tissue	$70
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350

(continued)

Code	Service	Member Copayment
Oral Maxillofacial Prosthetics (continued)		
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Nonarthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – lavage and lysis of adhesions	$350
D7874	Arthroscopy – disc repositioning and stabilization	$350
D7875	Arthroscopy – synovectomy	$350
D7876	Arthroscopy – discectomy	$350
D7877	Arthroscopy – debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290

(continued)

Code	Service	Member Copayment
Oral Maxillofacial Prosthetics (continued)		
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7961	Buccal/labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue – per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
D7979	Nonsurgical sialolithotomy	$155
D7980	Surgical sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
Orthodontics	Medically necessary banded case (The Copayment applies to a Member's course of treatment as long as that Member remains enrolled in this Plan)	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8091	Comprehensive orthodontic treatment with orthognathic surgery	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance – maxillary	
D8697	Repair of orthodontic appliance – mandibular	
D8698	Recement or re-bond fixed retainer – maxillary	
D8699	Recement or re-bond fixed retainer – mandibular	
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	
D8704	Replacement of lost or broken retainer – mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative treatment of dental Pain – per visit	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45
D9222	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	$45
D9223	Administration of Deep sedation/general anesthesia – each subsequent 15-minute increment, or any portion thereof	$45
D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	$65

(continued)

Code	Service	Member Copayment
Adjunctive General Services (continued)		
D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	$65
D9230	Administration of nitrous oxide	$15
D9239	Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	$60
D9243	Administration of moderate sedation – intravenous – each subsequent 15-minute increment, or any portion thereof	$60
D9244	In-office administration of minimal sedation – single drug – enteral	$30
D9245	Administration of moderate sedation – enteral	$65
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	$65
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	$65
D9310	Consultation – diagnostic service provided by dentist or Physician other than requesting dentist or Physician	$50
D9311	Consultation with a medical health professional	No Charge
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	$20
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12-month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12-month period per quadrant	$45
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)	$210
D9995	Teledentistry – synchronous; real-time encounter. Limited to twice in a 12-month period	No Charge
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12-month period	No Charge
D9997	Dental case management – patients with special health care needs	No Charge
D9999	Unspecified adjunctive procedure, by report	No Charge

Dental codes from "Current Dental Terminology© American Dental Association."

Optional Dental Coverage Included with HMO Plus Plans (for ages 19 and older)

Principal benefits and coverages for dental care with HMO Plus Plans

Dental coverage for HMO Plus Plans is provided by Health Net of California and administered by Dental Benefit Providers of California, Inc. This benefit is included only with HMO Plus Plans.

IMPORTANT: If you opt to receive dental services that are not Covered Benefits under this Plan, a Participating Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a Covered Benefit, the dentist should provide the patient with a treatment Plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net dental ID Card or your insurance broker. To fully understand your coverage, you may wish to carefully review the Evidence of Coverage document.

Selecting a dentist

Our dental Plan makes it easy for you to choose a personal dental provider. When you enroll, you must select a dentist for your entire family from our list of Primary Dentists for your area. To find a Primary Dentist online:

Step 1: Go to www.yourdentalportal.com/healthnet.

Step 2: Scroll down and click on Find a Dentist under "Find Your Dentist" in the center screen.

Step 3: Select Health Net DHMO CA ONLY from the Select a Network drop-down list.

Step 4: Select whether to search for a dentist either by location, by dentist name or by practice name.

Step 5: Enter your search criteria; then click on Submit at the bottom of the page for the results of the search.

You may change your Primary Dentist once a month. Primary dentist changes made prior to the 15th of the month are effective the first of the following month. Simply select a new dentist from the listing of Primary Dentists and call Health Net Dental's Customer Contact Center at **1-866-249-2382** with your change.

We also offer orthodontic coverage for adults and children. Simply select your orthodontist from the directory at any time during the year.

Copayments

Copayments are your share of costs for Covered Benefits and are paid to the dentist at the time of care. Your dental benefits do not have Deductibles or any annual maximum dollar benefit limitations. Simply present your Health Net dental Member ID card to the participating Primary Dentist you selected. It's that simple!

Copayments for dental services benefits under the HMO Plus Plans:

- Do not accrue toward your annual Out-of-Pocket Maximum;
- If your Plan has a Calendar Year Deductible, are not subject to that Deductible; and
- If your Plan has a Calendar Year Deductible, do not accrue toward that Deductible.

Medically Necessary Dental Services

Medically necessary dental services are dental benefits which are necessary and appropriate for treatment of a Member's teeth, gums and supporting structures according to professionally recognized standards of practice and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Please note: The Plus Plans are not available in all counties. Please see the Individual & Family Rate Guide for details.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC)* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Summary of dental benefits

Code	Covered Benefit	Member Pays
	Deductibles	none
	Lifetime maximums	none
Professional services –Diagnostic		
D0120	Periodic oral evaluation—established patient	No Charge
D0140	Limited oral evaluation – problem focused	No Charge
D0150	Comprehensive oral evaluation -- new or established patient	No Charge
D0210	X-rays intraoral – complete series (including bitewings)	No Charge
D0220	X-rays intraoral, periapical – first film	No Charge
D0230	X-rays intraoral, periapical – each additional film	No Charge
D0240	X-rays intraoral, occlusal film	No Charge
D0270	X-rays bitewing – single film	No Charge
D0272	X-rays bitewings – two films	No Charge
D0273	X-rays bitewings – three films	No Charge
D0274	X-rays bitewings – four films	No Charge
	Bitewing X-rays are limited to one series of four films in any 12-month period	
D0330	Panoramic film	No Charge
D0350	Oral/facial photographic images	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Charge
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No Charge
D0999	Unspecified diagnostic procedure by report	No Charge
Preventive		
D1110	Prophylaxis – initial	$8
D1110	Prophylaxis – second in same Calendar Year Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one "second" treatment every 12 months. An additional prophylaxis will be covered if determined to be Medically Necessary consistent with professional practice. For example, for high-risk patients, such as women who are pregnant, enrollees undergoing cancer chemotherapy, or enrollees with compromising systemic diseases such as diabetes.	$23
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$3
D1310	Nutritional counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant, per tooth	$5
D1510	Space maintainer—Fixed--unilateral	$75
D1516	Space maintainer—Fixed—bilateral, maxillary	$155
D1517	Space maintainer—Fixed—bilateral, mandibular	$155
D1520	Space maintainer—Removable--unilateral	$100
D1526	Space maintainer—Removable, bilateral, maxillary	$170
D1527	Space maintainer—Removable, bilateral, mandibular	$170
D1556	Removal of fixed unilateral space maintainer, per quadrant	$15
D1557	Removal of fixed bilateral space maintainer, maxillary	$15
D1558	Removal of fixed bilateral space maintainer, mandibular	$15

(continued)

Code	Covered Benefit	Member Pays
Restorative		
D2140	Amalgam – 1 surface, permanent	$25
D2150	Amalgam – 2 surfaces, permanent	$32
D2160	Amalgam – 3 surfaces, permanent	$41
D2161	Amalgam – 4 or more surfaces, permanent	$49
D2330	Resin-based composite – 1 surface, anterior	$35
D2331	Resin-based composite – 2 surfaces, anterior	$45
D2332	Resin-based composite – 3 surfaces, anterior	$55
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)	$65
Crowns – Single Restorations Only		
D2710	Crown—resin-based composite (indirect)	$240*
D2712	Crown—3/4 resin-based composite (indirect)	$240*
D2720	Crown—resin with high noble metal	$240*
D2721	Crown—resin with predominantly base metal	$240*
D2722	Crown—resin with noble metal	$240*
D2750	Crown—porcelain fused to high noble metal	$305*
D2751	Crown—porcelain fused to predominantly base metal	$305*
D2752	Crown—porcelain fused to noble metal	$305*
D2780	Crown—3/4 cast high noble metal	$280*
D2781	Crown—3/4 cast predominantly base metal	$280*
D2782	Crown—3/4 cast noble metal	$280*
D2790	Crown – full cast high noble metal	$280*
D2791	Crown--full cast predominantly base metal	$280*
D2792	Crown--full cast noble metal	$280*
D2794	Crown—titanium	$280*
D2910	Recement inlay, onlay, or partial coverage restoration	$15
D2915	Recement cast or prefabricated post and core	$15
D2920	Recement crown	$21
D2930	Prefabricated stainless steel crown (primary tooth)	$55
D2931	Prefabricated stainless steel crown (permanent tooth)	$65
D2940	Sedative filling	$20
D2950	Core build-up (including any pins)	$23*
D2951	Pin retention – per tooth in addition to restoration	$20*
D2952	Post and core in addition to crown, indirectly fabricated	$100*
02953	Each additional indirectly fabricated post—same tooth	$100*
D2954	Prefabricated post and core in addition to crown	$60
	* In addition to the noted Copayment, you will also be responsible for the actual lab cost of noble or high noble metal.	
Endodontics (per tooth)		
D3110	Pulp cap, direct (excluding final restoration)	$21
D3120	Pulp cap, indirect (excluding final restoration)	$21
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament	$33
D3310	Anterior (excluding final restoration)	$170
D3320	Bicuspid (excluding final restoration)	$220
D3330	Molar (excluding final restoration)	$290
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$170
D3346	Retreatment of previous root canal therapy--Anterior	$185
D3347	Retreatment of previous root canal therapy Bicuspid	$240
D3348	Retreatment of previous root canal therapy Molar	$315
D3410	Apicoectomy/periradicular surgery--anterior	$155
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)	$155
D3425	Apicoectomy/periradicular surgery—molar (first root)	$155

(continued)

Code	Covered Benefit	Member Pays
Endodontics (per tooth) (continued)		
D3426	Apicoectomy (each additional root)	$75
D3430	Retrograde filling, per root	$48
D3450	Root amputation, per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$85
Periodontics		
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	$230
D4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or bounded teeth spaces, per quadrant	$33
D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or bounded teeth spaces, per quadrant	$30
D4260	Osseous surgery, including flap entry and closure—four or more contiguous teeth or bounded teeth spaces, per quadrant	$290
D4261	Osseous surgery, including flap entry and closure—one to three contiguous teeth or bounded teeth spaces, per quadrant)	$290
D4341	Periodontal Scaling and root planing—four or more teeth, per quadrant	$30
D4342	Periodontal scaling and root planing—one to three teeth, per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$20
Prosthodontics (Removable) Note(s): Dentures replaced within any five-year period are not covered.		
D5110	Complete denture – maxillary	$405
D5120	Complete denture – mandibular	$405
D5130	Immediate denture – maxillary	$420
D5140	Immediate denture – mandibular	$420
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests & teeth)	$290
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests & teeth)	$290
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth)	$385
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth)	$385
D5410	Adjust complete denture – maxillary	$15
D5411	Adjust complete denture – mandibular	$15
D5421	Adjust partial denture – maxillary	$15
D5422	Adjust partial denture – mandibular	$15
D5511	Repair broken complete denture base, mandibular	$15
D5512	Repair broken complete denture base, maxillary	$15
D5520	Replace missing or broken teeth – complete denture (each tooth)	$53
D5611	Repair resin partial denture base, mandibular	$15
D5612	Repair resin partial denture base, maxillary	$15
D5621	Repair cast partial framework, mandibular	$15
D5622	Repair cast partial framework, maxillary	$15
D5630	Repair or replace broken clasp	$63
D5640	Replace broken teeth – per tooth	$53
D5650	Add tooth to existing partial denture	$58
D5660	Add clasp to existing partial denture	$63
D5710	Rebase complete maxillary denture	$185
D5711	Rebase complete mandibular denture	$185
D5720	Rebase maxillary partial denture	$185
D5721	Rebase mandibular partial denture	$185
D5730	Reline complete maxillary denture (chairside)	$70
D5731	Reline complete mandibular denture (chairside)	$70
D5740	Reline maxillary partial denture (chairside)	$70
D5741	Reline mandibular partial denture (chairside)	$70
D5750	Reline complete maxillary denture (laboratory)	$120

(continued)

Code	Covered Benefit	Member Pays
Prosthodontics (Removable) Note(s): Dentures replaced within any five-year period are not covered.(continued)		
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120
D5761	Reline mandibular partial denture (laboratory)	$120
D5820	Interim partial denture (maxillary)	$135
D5821	Interim partial denture (mandibular)	$135
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
Prosthodontics (Fixed)		
D6205	Pontic – indirect resin-based composite	$280*
D6210	Pontic – cast high noble metal	$280*
D6211	Pontic – cast predominantly base metal	$280
D6212	Pontic – cast noble metal	$280*
D6214	Pontic – titanium	$305*
D6240	Pontic – porcelain fused to high noble metal	$305*
D6241	Pontic – porcelain fused to predominantly base metal	$305*
D6242	Pontic – porcelain fused to noble metal	$305*
D6710	Crown – indirect resin-based composite	$305*
D6750	Crown – porcelain fused to high noble metal	$305*
D6751	Crown – porcelain fused to predominantly base metal	$305*
D6752	Crown – porcelain fused to noble metal	$305*
D6780	Crown – ¾ cast high noble metal	$280*
D6781	Crown – ¾ cast predominantly base metal	$280*
D6782	Crown – ¾ cast noble metal	$280*
D6790	Crown – full cast high noble metal	$280*
D6791	Crown – full cast predominantly base metal	$280*
D6792	Crown – full cast noble metal	$280*
D6794	Crown – titanium	$280*
D6930	Recement fixed partial denture. Fixed bridgework will be covered only when a removable partial denture cannot satisfactorily restore the case.	$23
D9120	Fixed partial denture sectioning	No Charge
	*In addition to the noted Copayment, you will also be responsible for the actual lab cost of noble or high noble metal.	
Oral and Maxillofacial Surgery		
D7111	Extraction- coronal remnants – deciduous tooth	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Charge
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth--soft tissue	$70
D7230	Removal of impacted tooth--partial bony	$105
D7240	Removal of impacted tooth--complete bony	$135
D7250	Surgical Removal of residual tooth roots (cutting procedure)	$50
	Other Services	
D9930	Treatment of complications (post-surgical – unusual circumstances, by report)	$11
D9951	Occlusal Adjustment – limited (per quadrant)	$27
D9952	Occlusal Adjustment – complete (per quadrant)	$27
D9999	Transfer of all materials with less than a full mouth x-ray	$20
D9999	Transfer of all materials with a full mouth x-ray	$20
D9999	Operatory preparation fee (payable per visit in addition to any applicable Copayments for Covered Benefits rendered)	$20
	Note(s): The Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.	

Code	Covered Benefit	Member Pays
Adjunctive General Services		
D9110	Palliative (Emergency) treatment of dental Pain – minor procedure	$14
D9995	Teledentistry – synchronous; real-time encounter	No Charge
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	No Charge
	Note(s): • The "Emergency visits during regular dental office hours" copay is for the cost of the palliative treatment only. If additional services are provided, the applicable Copayment for the service as stated in this Schedule of Benefits and Copayments will apply. Teledentistry is limited to twice in a 12-month period	

Code	Professional Visits	Copayment
D9440	Office visits – after regularly scheduled hours	$55
	Note(s): The "Emergency visits after normal dental office hours" copay is for the cost of the afterhours emergency visit only. If additional services are provided, the applicable Copayment for the service as stated in this Schedule of Benefits and Copayments will apply.	
Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,000
D8210	Removable appliance therapy	$115
D8220	Fixed appliance therapy	$220
D8670	Periodic orthodontic treatment visit	No Charge

Limitation(s):
This benefit is limited to 24 months of usual and customary orthodontic banding.

Note(s):
Occasionally an instance arises where the general dentist deems that the services of a Specialist are required. Health Net can assist the Member with a referral to a Specialist. However, there is no coverage under the Plan for services rendered by a Specialist except for orthodontic care.

Dental codes from "Current Dental Terminology© American Dental Association."

Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic Health Care Services required to be covered under California or federal law, including, but not limited to, Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

General Exclusions and Limitations

Acupuncture Services

This Plan does not cover Acupuncture Services, except as described in the EOC in the "Schedule of Benefits and Copayments" section and the "Covered Services and Supplies" section or as required by law.

Chiropractic Services

This Plan does not cover Chiropractic Services, except as required by law.

Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, device or service itself;
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in the EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in the EOC in the "General Provisions" section or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in the EOC in the "General Provision" section.

Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the EOC in the "Covered Services and Supplies" section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the EOC in the "Covered Services and Supplies" section, or as required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in the EOC in the "Covered Services and Supplies" section.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by Physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC in the "Covered Services and Supplies" section.

Custodial or Domiciliary Care

This Plan does not cover Custodial Care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, or domiciliary care, which involves a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, or inpatient Hospital care or services provided in a health care facility, including Mental Health or Substance Use Disorder services.

Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in the EOC in the "Covered Services and Supplies" section under "Ostomy and Urological Supplies" or as required by law.

Experimental or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional Specialists pertinent to the specific service;
3. Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.

3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible Physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in the EOC in the "General Provisions" section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the "General Provisions" section.

Hearing Aids

This Plan does not cover hearing aids, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.

Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Nonlicensed or Noncertified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Prescription Drugs/Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as described in the EOC in the "Covered Services and Supplies" section or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:

o Insulin,

o Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),

- Over-the-counter drugs for reversal of an opioid overdose, or
- An entire class of Prescription Drugs when one drug within that class becomes available over the counter.

- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a Plan or a Plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

Private Duty Nursing

This Plan does not cover Private Duty Nursing in the home, Hospital, or long-term care facility, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.

Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under the EOC in the "Covered Services and Supplies" section or as required by law.

Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a Surrogate pregnancy, except as described in the EOC in the "Surrogacy Arrangements" provision in the "General Provisions" section or as required by law.

Therapies

This Plan does not cover the following physical and occupational therapies, except as described in the EOC in the "Covered Services and Supplies" section or as required by law:

- Massage therapy, unless it is a component of a treatment Plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in the EOC in the "Covered Services and Supplies" section, as otherwise described in the EOC in the "Covered Services and Supplies" section or as required by law.

Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as described in the EOC in the "Covered Services and Supplies" section or as required by law.

Dental Exclusions and Limitations

Adult Dental Services

This Plan does not cover dental services or supplies for Members age 19 and older, except as required by law.

Pediatric Dental Services

This Plan does not cover dental services or supplies for Members up to age 19, except as described in the EOC in the "Medically Necessary Dental Services" provision of the "Covered Services and Supplies" section of the EOC or as required by law. The exclusions and limitations for covered pediatric dental services are provided below.

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Pediatric Dental Services. See the "Pediatric Dental Services" portion of the "Schedule of Benefits and Copayments" section for additional limitations.

Note: Services or supplies excluded under the dental benefits may be covered under your medical benefits portion of this *Plan Contract and Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for more information.

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

Except as otherwise provided in the "Pediatric Dental Services" portion of "Covered Services and Supplies," all benefits must be provided by a Health Net Participating Dentist in order to be covered. This dental Plan does not provide benefits for services and supplies provided by a dentist who is not the Participating Dentist, except as specifically described under the "Pediatric Dental Services portion of "Introduction to Health Net " section.

Additional exclusions and limitations:

Implant Services (D6000-D6199)

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.

Medically Necessary Orthodontia (D8000-D8999)

Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a Member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

a. Only those cases with permanent dentition shall be considered for Medically Necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed, and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

b. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

c. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed Specialist on their professional letterhead.

d. The automatic qualifying conditions are:

   i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,

   ii. Craniofacial anomaly. Written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,

   iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

   iv. A crossbite of individual anterior teeth causing destruction of soft tissue,

   v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

   vi. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the Prior Authorization request.

If a Member does not score 26 or above nor meets one of the six automatic qualifying conditions, they may be eligible under the Early and Periodic Screening, Diagnosis and Treatment – Supplemental Services (EPSDT-SS) exception if medical necessity is documented.

Adjunctive Services (D9000-D9999)

Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;

- Palliative treatment (relief of Pain).
- Palliative (emergency) treatment, for treatment of dental Pain, limited to once per day, per Member.
- House/extended care facility calls, once per Member per date of service.
- One Hospital or ambulatory surgical center call per day per provider per Member.
- Anesthesia for Members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require Prior Authorization.
- Occlusal guards when Medically Necessary and prior authorized, for Members from 12 to 19 years of age when Member has permanent dentition.

The following services, if in the opinion of the attending dentist or Health Net are not Medically Necessary, will not be covered:

- Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
- Any procedure that in the professional opinion of the attending dentist: (a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or (b) is inconsistent with generally accepted standards for dentistry.
- Temporomandibular joint treatment (aka "TMJ").
- Elective dentistry and cosmetic dentistry.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.
- Prescription medications.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Any procedure of implantation.
- Any Experimental Services procedure. Experimental Services treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process. Please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section set forth in the *Plan Contract and Evidence of Coverage* for your health Plan with Health Net for more information.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member's responsibility. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a Covered Benefit.
- Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county, or other subdivisions.

- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member becomes eligible for such services.
- Dispensing of drugs not normally supplied in a dental office.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by their panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or their Plan provider is a pedodontist/pediatric dentist.
- Dental services that are received in an emergency setting for conditions that are not emergencies if the Member reasonably should have known that an emergency situation did not exist.
- Services from a nonnetwork provider.

Missed Appointments

Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.

Vision Exclusions and Limitations

Adult Vision Services

This Plan does not cover the following vision services for Members up to age 19, except as described in the EOC in the "Covered Services and Supplies" section or as provided as a supplemental benefit or as required by law. The exclusions and limitations for covered pediatric vision services are provided below.

Pediatric Vision Services

This Plan does not cover the following vision services for Members up to age 19, except as described in the EOC in the "Covered Services and Supplies" section or as required by law. The exclusions and limitations for covered pediatric vision services are provided below.

The exclusions and limitations in the "Services and Supplies" portion of this section apply to Pediatric Vision Services.

Note: Services or supplies excluded under the vision benefits may be covered under your medical benefits portion of this *Plan Contract and Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section, for more information.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

Additional exclusions and limitations:

Nonparticipating Providers

This vision Plan will not cover services and supplies provided by a provider who is not a Participating Vision Provider.

Not-Medically Necessary Services and Materials

Charges for services and materials that Health Net determines to be non-Medically Necessary services, are excluded. One routine eye examination with dilation is covered every Calendar Year and is not subject to medical necessity.

Medically Necessary Contact Lenses

Coverage for prescriptions for contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses' lenses and frames. See the "Pediatric Vision Services" portions of "Schedule of Benefits" and "Covered Services and Supplies" for details.

Medical or Hospital

Hospital and medical charges of any kind, vision services rendered in a Hospital and medical or surgical treatment of the eyes, are not covered.

Loss or Theft

Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this Plan.

Orthoptics, Vision Training, etc.

Orthoptics and vision training and any associated testing, subnormal vision aids, plano (nonprescription) lenses, lenses are excluded unless specifically identified as a Covered Benefit in the "Pediatric Vision Services" portion of the "Schedule of Benefits" section.

Second Pair

A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

Employment Related

Any services or materials as a condition of employment (e.g., safety glasses). Noted exception: If the service is determined to be Medically Necessary, irrespective of whether a condition of employment also requires it, the service is covered.

Medical Records

Charges associated with copying or transferring vision records are excluded. Noted exception: If Health Net's contracting provider terminates, lacks capacity or the enrollee is transferred for other good cause, the enrollee is not required to pay the charges associated with copying or transferring vision records to the participating provider in order to obtain Covered Benefits.

Principal exclusions and limitations for dental care with HMO Plus Plans

All Medically Necessary services are covered if performed by the Member's Primary Dentist. If services of a dental Specialist are required, the Member will be responsible for the Specialist's fees.

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or b) is inconsistent with generally accepted standards for dentistry.
- Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one subsequent treatment every 12 months.
- Fluoride treatment is covered twice in any 12-month period.
- bitewing X-rays are limited to one series of four films in any 12-month period.
- Full-mouth X-rays are limited to once every 36 months or as needed consistent with professional practice guidelines.
- Periodontal treatments (subgingival curettage and root planing) are limited to five in any 12-month period.
- Replacement of a restoration is covered only when it is Medically Necessary.
- Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Partial dentures will be replaced as Medically Necessary consistent with professional standards of practice.
- Full upper and/or lower dentures will be replaced as Medically Necessary consistent with professional standards of practice.
- Services that, in the opinion of the attending dentist or Health Net, are not Medically Necessary.
- Any Experimental Services procedure. Experimental treatment if denied may be appealed through the Independent Medical Review (IMR) process and that service shall be covered and provided if required under the Independent Medical Review (IMR) process.
- Any procedure of implantation.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a Covered Benefit.
- Elective dentistry and cosmetic dentistry.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member's responsibility. However, the Copayment for missed appointments may not apply if: (a) the Member canceled at least 24 hours in advance; or (b) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- General anesthesia or intravenous/conscious sedation. However, such services may be covered under the medical services portion of this Plan. See the Plan's *Plan Contract and EOC* for details.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Prescription medications.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Temporomandibular joint treatment (TMJ).
- Treatment of malignancies, cysts, neoplasms, or congenital malformations.

Dental Plan general provisions

An additional charge will be required for missed appointments. Missed appointments without 24 hours' notice will be charged an additional charge. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.

Orthodontic benefits

The orthodontic Copayment charged by Health Net for children through age 19 will be $1,800 per case. Adults aged 20 or older will be charged an orthodontic Copayment of $2,000 per case. This benefit is limited to 24 months of usual and customary orthodontic banding.

Principal orthodontic exclusions and limitations

Health Net reserves the right to limit coverage to its choice of Participating Dentists

Principal benefits and coverages for vision provided with HMO Plus Plans

Provided by Health Net of California. Health Net contracts with EyeMed Vision Care, LLC to provide vision services benefits. This benefit is included only with HMO Plus Plans.

We make it easy for you to choose a personal vision care provider. You can select from a large network of providers, including optometrists, ophthalmologists and dispensing opticians. For names, addresses and phone numbers of Participating Vision Providers, visit **www.myhealthnetca.com.** If you need help in selecting a provider, call the Health Net Vision Member Services Department at **1-866-392-6058.**

Copayments for vision services benefits under the HMO Plus Plans:

- Do not accrue toward your annual Out-of-Pocket Maximum;
- If your Plan has a Calendar Year Deductible, are not subject to that Deductible; and
- If your Plan has a Calendar Year Deductible, do not accrue toward that Deductible.

Benefits and coverage matrix for vision care provided with HMO Plus Plans

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC)* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Summary of vision benefits

Covered benefits	Member pays
Deductibles	None
Lifetime maximums	None
Professional services	
Examination with dilation	$10
Examination for contact lens	
Standard contact lens fit and follow-up	up to $55
Premium contact lens fit and follow-up	10% off retail
Materials	
Frames (once every 12 months)	$0 plus 20% off the balance over the $80 allowance
Standard plastic eyeglass lenses (once every 12 months)	
Single vision	$40
Bifocal	$40
Trifocal	$40
Lenticular	$40
Standard progressive lenses	$105
Premium progressive lenses	$105 copay, plus 20% off the balance over the $120 allowance
Lens options (in addition to standard lenses)	
UV coating	20% off retail price
Tint (solid and gradient)	20% off retail price
Standard plastic scratch-resistance	20% off retail price
Standard polycarbonate	20% off retail price
Standard anti-reflective	20% off retail price
Other add-ons and service	20% off retail price
Contact lenses (every 12 months) (in lieu of eyeglass lenses; includes material only):	
Medically Necessary contact lenses[1]	$0
Non-Medically Necessary contact lenses	
Conventional contact lenses	$0, plus 15% off the balance over the $80 allowance
Disposable contact lenses	$0, plus balance over the $80 allowance

Limitation: In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every 12 months.

Benefits may not be combined with any discounts, promotional offerings or other group benefit Plans. Allowances are one time use benefits. No remaining balance.

Examination for contact lenses is in addition to the Member's vision examination. There is no additional Copayment for contact lens follow-up visit after the initial fitting examination.

[1]Contact lenses are defined as Medically Necessary if the individual is diagnosed with one of the following conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

Vision examination
In accordance with professionally recognized standards of practice, this exam will include an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

Frames
If the exam indicates the necessity of eyeglasses, this vision Plan will cover a frame once every 12 months up to a maximum of $80 retail frame allowance plus 20 percent off balance over allowance. If the Member selects frames that are more expensive than this allowance, the Member will be charged 80% of the difference between the allowance and the retail cost of the more expensive frames.

Eyeglass Lenses
If the exam results in corrective lenses being prescribed for the first time, or if a current wearer of corrective lenses needs new lenses, this vision Plan will cover a pair of lenses at the service level indicated above. Coverage is limited to standard single vision, bifocal, trifocal or lenticular plastic lenses that are Medically Necessary to correct vision.

Medically necessary contact lenses
Coverage of Medically Necessary contact lenses is subject to medical necessity.

Non-medically necessary conventional or disposable contact lenses
Non medically necessary conventional or disposable contact lenses are covered up to a maximum retail allowance of $80. When covered, non-medically necessary contact lenses will be provided in lieu of eyeglass lenses and will be provided at the same interval as eyeglass lenses. If the Member selects contact lenses that are more expensive than this allowance, the Member will be responsible for the provider's charges in excess of this allowance as noted above.

Second pair
Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

Principal exclusions and limitations for vision benefits provided with Health Net HMO Plus Plans
The following vision services and expenses are not covered under the HMO Plus Plans:

- Coverage limited to care rendered by Participating Vision Providers.
- Extras and non-medically necessary services and materials. Charges for services and materials are excluded if Health Net determines them to be: (1) beyond the allowances for frames, lenses and contact lenses indicated in the Summary of Vision Benefits; or (2) otherwise non-medically necessary services.
- Medically necessary contact lenses. Coverage for prescriptions for contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision Plan. This coverage is in lieu of all eyeglass lenses and frames.
- Non-medically necessary contact lenses. Prescriptions for contact lenses that are not Medically Necessary are covered up to the maximum retail contact lens benefit allowance indicated above. This coverage is in lieu of eyeglass lenses at the same interval as eyeglass lenses. The allowance applies to all costs associated with obtaining contact lenses. If the Member selects contact lenses that are more expensive than this allowance, the Member will be responsible for the provider's charges in excess of the allowance.
- Medical or Hospital. Hospital and medical charges of any kind, vision services rendered in a Hospital, and medical or surgical treatment of eyes, are excluded.
- Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular intervals of coverage under this vision Plan.
- Orthoptics and vision training and any associated testing, subnormal vision aids, and plano (non-prescription) lenses.
- A second pair of glasses in lieu of bifocals is excluded.

Please refer to the *Plan Contract and Evidence of Coverage* for a complete listing of exclusions and limitations.

Members' Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's Member rights and responsibilities policy.
- Receive information about all Health Care Services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your Deductible or Out-of-Pocket Maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a Specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network HealthCare Provider.
- Certain accommodations for your disability, including
  - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - Full and equal access, as other members of the public, to medical facilities.
  - Extra time for visits if you need it.
  - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment Plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or Deductible.
- Have no annual or lifetime dollar limits on basic Health Care Services.
- Keep eligible Dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified HealthCare Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your Medical Information related to Sensitive Services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health Plan to change information about you in your medical records if it is not correct or complete. Your doctor or health Plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive Health Care Services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - Your Plan or Health Care Provider.
  - Any care you receive, or access to care you seek.
  - Any Covered Benefit or benefit decision that your Plan makes.
  - Any improper charges or bills for care.
  - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing Health Care Services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a Health Care Service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your HealthCare Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your HealthCare Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or Family Members covered under your Plan.
- Timely pay any premiums, Copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Definitions

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by ASH Plan to be Medically Necessary for the treatment of that condition. Acupuncture Services are typically provided only for the treatment of nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain.

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Benefits shall be provided for the duration of the Acute Condition.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Ambetter from Health Net Drug List is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at **www.myhealthnetca.com.** Some Drugs in the Ambetter from Health Net Drug List require Prior Authorization from Health Net in order to be covered.

American Specialty Health Plans of California, Inc. (ASH Plans) is a specialized Health Care Service Plan contracting with Health Net to arrange the delivery of Acupuncture Services through a network of Contracted Acupuncturists.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following: o The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - » The United States Department of Veterans Affairs.
    - » The United States Department of Defense.
    - » The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name and indicated as a brand in the Medi-Span or similar third-party national database used by Health Net .

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Acupuncture Services to Members.

Copayment is a fee charged to you for Covered Benefits when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each Covered Benefit is shown in the "Schedule of Benefits and Copayments" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health Plan law.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and which patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of nonemergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for Emergency Services and Care or the ongoing care provided by a Physician.

CVS MinuteClinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the state of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

Deductible is a set amount you pay each Calendar Year for specified Covered Expenses before Health Net pays any benefits for those Covered Expenses in that Calendar Year. Refer to the "Schedule of Benefits and Copayments" section for the services that are subject to Deductibles and the Deductible amounts.

Dependent includes:

- The Subscriber's lawful spouse, as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined below.)
- The children of the Subscriber or their spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).
- A parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Service Area.

Domestic Partner is, for the purposes of this *Plan Contract and Evidence of Coverage*, the Subscriber's partner if the Subscriber and partner are a couple who are registered Domestic Partners that meet all the requirements of Section 297or 299.2 of the California Family Code.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, it is not for convenience and/or comfort, and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the Plan.

Emergency Dental Care includes Medically Necessary services required for: (1) the alleviation of severe Pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions. However, payment for Emergency Dental Care rendered will be conditioned on Health Net's subsequent review and determination as to consistency with professionally recognized standards of dental practice and Health Net's dental policies.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe Pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a Physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a Physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Essential Health Benefits are a set of Health Care Service categories (as defined by the Affordable Care Act) that must be covered by all health benefits Plans starting in 2014. Categories include: ambulatory patient services, Emergency Services and Care, hospitalization, maternity and newborn care, Mental Health or Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Evidence of Coverage (EOC) means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third-party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a Health Care Provider by the state of California to perform the services, acting within the scope of their license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed Health Care Service Plan.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in their place of residence that is prescribed by the Member's attending Physician as part of a written Plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are Covered Benefits under this Plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician -defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for Health Care Services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1) Testing is not complete; and

2) The efficacy and safety of such services in human subjects are not yet established; and

3) The service is not in wide usage.

- Life-Threatening means either or both of the following:
  - Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to a drug treatment Plan with a specific medication at a constant dosage requirement.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health Plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, Health Care Service Plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the Health Care Service Plan and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member means a Subscriber, enrollee, enrolled employee, or Dependent of a Subscriber or an enrolled employee, who has enrolled in the Health Net Plan and for whom coverage is active or live.

Member Physician is a Physician who practices medicine as an associate of a Physician Group.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments [and Deductibles] you must pay for Covered Benefits for each Calendar Year.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net, to provide Mental Health or Substance Use Disorder benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or substance use disorder rehabilitation services.

Participating Dentist is a dentist or dental facility licensed to provide benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Dentists are set forth in Health Net's Participating Dentist Directory. The names of Participating Dentists and their locations and hours of practice may also be obtained by contacting Health Net's Customer Service Department. This Plan does not guarantee the initial or continued availability of any particular Participating Dentist.

Participating Mental Health Professional is a Physician or other professional who is licensed, certified or otherwise authorized by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health or Substance Use Disorder services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Participating Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish such care to Members.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

Physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is the Health Net contracting medical group the individual Member selected as the source of all covered medical care. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by you and described in this Plan Contract.

Plan Contract or *Plan Contract and Evidence of Coverage* (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "Prescription Drug'' includes: (A) disposable devices that are Medically Necessary for the administration of a covered Prescription Drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable Prescription Drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the Prescription Drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health Plan, any vaccines or other health care benefits covered under the Health Net Plan's Prescription Drug benefit.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in the "Schedule of Benefits and Copayments" section, and the "Covered Services and Supplies" section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health
- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician is a Member Physician who coordinates and controls the delivery of Covered Benefits and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician. [You must visit your Primary Care Physician for the lowest office visit Copayment.]

Primary Dentist is any Participating Dentist who has the responsibility for providing benefits to Members, maintaining the continuity of patient care, initiating referral for orthodontic care and who is listed in the current Participating Dentist Directory for your area as a Primary Dentist.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements not otherwise specified in this document, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" portion of "Covered Services and Supplies" for details regarding the Prior Authorization process relating to Prescription Drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a noninstitutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care and includes any portion of shift care services."

Protected Individual means any adult covered by the Subscriber's Health Care Service Plan or a minor who can consent to a Health Care Service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A Health Care Service Plan shall not require a Protected Individual to obtain the Subscriber or other enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the Protected Individual has the right to consent to care.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board with a certification, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment Plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional:
  - A. Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;
  - B. Is supervised by a Qualified Autism Service Provider;
  - C. Provides treatment pursuant to a treatment Plan developed and approved by the Qualified Autism Service Provider; and is either of the following:
  - D. Is either of the following:
  - i. Is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; or
  - ii. A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology;
  - E. Is either of the following:
    - i. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; or
    - ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional;
  - F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment Plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment Plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment Plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a telehealth service provider that is contracted with Health Net to provide Telehealth Services that are covered under the "Telehealth Consultations through the Select Telehealth Services Provider" heading as shown in the "Schedule of Benefits and Copayments" and "Covered Services and Supplies" sections. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Sensitive Services means all Health Care Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929, 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the Plan within which a Plan shall provide Health Care Services.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Subscriber is the person enrolled under this Plan Contract who is responsible for payment of premiums to Health Net and whose status is the basis for family Member eligibility under this Plan Contract.

Substance Use Disorder Care Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is state-licensed to provide substance use disorder detoxification services or rehabilitation services.

Surrogacy Arrangement means an understanding in which a person (the Surrogate) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the Surrogate receives payment for acting as a Surrogate.

Surrogate means an individual who, as part of a Surrogacy Arrangement, (a) uses their own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in their body, but the egg is not their own.

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Teledentistry can include patient care and education. See the definition of "Telehealth Services" below.

Telehealth Services means the mode of delivering Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

For the purposes of this definition, the following apply:

- "Asynchronous store and forward" means the transmission of a patient's Medical Information from an originating site to the Health Care Provider for telehealth at a distant site without the presence of the patient.
- "Distant site" means a site where a Health Care Provider for telehealth who provides Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Health Care Services are provided via telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a Health Care Provider for telehealth located at a distant site.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Benefits shall be provided for the duration of a Terminal Illness.

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs.

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy and cost.

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 Drugs (Specialty Drugs) are Prescription Drugs listed in the Ambetter from Health Net Drug List and include drugs: (a) that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; (b) that require the Member to have special training or clinical monitoring for self-administration; or (c) with a cost to Health Net that is greater than six hundred dollars ($600) net of rebates for a one-month supply.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

Urgently Needed Care includes otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of their health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, if you have an ID card, please call the Customer Contact Center number. Employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة، يرجى الاتصال برقم مركز خدمة العملاء المبين على بطاقتك. فيما يتعلق بمقدمي طلبات مجموعة صاحب العمل، يرجى التواصل مع مركز الاتصال التجاري في Health Net عبر الرقم: 1-800-522-0088 (TTY: 711). فيما يتعلق بمقدمي طلبات خطة الأفراد والعائلة، يرجى الاتصال بالرقم 1-877-609-8711 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Եթե ID քարտ ունեք, օգնության համար խնդրում ենք զանգահարել Հաճախորդների սպասարկման կենտրոնի հեռախոսահամարով: Գործատուի խմբի դիմորդներին խնդրում ենք զանգահարել Health Net-ի Կոմերցիոն սպասարկման կենտրոն՝ 1-800-522-0088 հեռախոսահամարով (TTY՝ 711): Individual & Family Plan (IFP) դիմորդներին խնդրում ենք զանգահարել 1-877-609-8711 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助且如果您有會員卡，請撥打客戶聯絡中心電話號碼。雇主團保計畫的申請人請撥打 1-800-522-0088（聽障專線：711）與 Health Net 私人保險聯絡中心聯絡。Individual & Family Plan (IFP) 的申請人請撥打 1-877-609-8711（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, यदि आपके पास आईडी कार्ड है तो कृपया ग्राहक संपर्क केंद्र के नंबर पर कॉल करें। नियोक्ता सामूहिक आवेदक कृपया हेल्थ नेट के कमर्शियल संपर्क केंद्र को 1-800-522-0088 (TTY: 711) पर कॉल करें। व्यक्तिगत और फैमिली प्लान (आईएफपी) आवेदक कृपया 1-877-609-8711 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab cuam, yog tias koj muaj daim npav ID, thov hu rau Neeg Qhua Lub Chaw Tiv Toj tus npawb. Tus tswv ntiav neeg ua haujlwm pab pawg sau ntawv thov ua haujlwm thov hu rau Health Net Qhov Chaw Tiv Toj Kev Lag Luam ntawm 1-800-522-0088 (TTY: 711). Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) cov neeg thov ua haujlwm thov hu rau 1-877-609-8711 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプについては、IDカードをお持ちの場合は顧客連絡センターまでお電話ください。雇用主を通じた団体保険の申込者の方は、Health Netの顧客連絡センター（1-800-522-0088、TTY: 711）までお電話ください。個人・家族向けプラン（IFP）の申込者の方は、1-877-609-8711（TTY: 711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យ លោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានប័ណ្ណសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំគម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-877-609-8711 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하십시오. 고용주 그룹 신청인의 경우 Health Net의 상업 고객서비스 센터에 1-800-522-0088(TTY: 711)번으로 전화해 주십시오. 개인 및 가족 플랜(IFP) 신청인의 경우 1-877-609-8711(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada’iiyeed. Ata’ halne’ígíí da ła’ ná hádídóot’įįł. Naaltsoos da t’áá shí shizaad k’ehjí shichį́’ yídooltah nínízingo t’áá ná ákódoolnííł. Ákót’éego shíká a’doowoł nínízingo Customer Contact Center hoolyéhíjį’ hodíílnih ninaaltsoos nanitingo bee néého’dolzinígíí hodoonihjį’ bikáá’. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį’ hodíílnih Health Net’s Commercial Contact Center 1-800-522-0088 (TTY: 711). T’áá hó dóó ha’áłchíní (IFP) báhígíí éí kojį’ hojilnih 1-877-609-8711 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، اگر کارت شناسایی دارید، لطفاً با شماره مرکز تماس مشتریان تماس بگیرید. متقاضیان گروه کارفرما لطفاً با مرکز تماس تجاری Health Net به شماره 1-800-522-0088 (TTY:711) تماس بگیرند. متقاضیان طرح فردی و خانوادگی (IFP)* لطفاً با شماره 1-877-609-8711 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਜੇ ਤੁਹਾਡੇ ਕੋਲ ਇੱਕ ਆਈਡੀ ਕਾਰਡ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਮਾਲਕ ਦਾ ਗਰੁੱਪ ਬਿਨੈਕਾਰ, ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈੱਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਬਿਨੈਕਾਰਾਂ ਨੂੰ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь и у Васпри себе есть карточка участника плана, звоните по телефону Центра помощи клиентам. Участники коллективных планов, предоставляемых работодателем: звоните в коммерческий центр помощи Health Net по телефону 1-800-522-0088 (TTY: 711). Участники планов для частных лиц и семей (IFP): звонитепо телефону 1-877-609-8711 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, si tiene una tarjeta de identificación, llame al número del Centro de Comunicación con el Cliente. Los solicitantes del grupo del empleador deben llamar al Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, kung mayroon kayong ID card, mangyaring tumawag sa numero ng Customer Contact Center. Para sa mga grupo ng mga aplikante ng tagapag-empleyo, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Planong Pang-indibiduwal at Pampamilya (Individual & Family Plan, IFP), mangyaring tumawag sa 1-877-609-8711 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ และคุณมีบัตรประจำตัว โปรดโทรหมายเลขศูนย์ลูกค้าสัมพันธ์ ผู้สมัครกลุ่มนายจ้าง โปรดโทรหาศูนย์ลูกค้าสัมพันธ์เชิงพาณิชย์ของ Health Net ที่หมายเลข 1-800-522-0088 (โหมด TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว (Individual & Family Plan: IFP) โปรดโทร 1-877-609-8711 (โหมด TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nế u quý vị có thẻ ID, vui lòng gọi đến số điện thoại của Trung Tâm Liên Lạc Khách Hàng. Những người nộp đơn xin bảo hiểm nhóm qua hãng sở vui lòng gọi Trung Tâm Liên Lạc Thương Mại của Health Net theo số 1-800-522-0088 (TTY : 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình (IFP), vui lòng gọi số 1-877-609-8711 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FOR MORE INFORMATION, PLEASE CONTACT:

Health Net Individual & Family Ambetter HMO Plans

P.O. Box 989731
West Sacramento, CA 95798-9731

Individual & Family Plans:

1-800-909-3447
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9053 (Mandarin)
1-800-331-1777 (Spanish)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device
for the Hearing and Speech Impaired:

1-800-995-0852

www.myhealthnetca.com

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