Health Net of California, Inc. (Health Net)

Individual & Family Plans

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Individual & Family Ambetter PPO Plans

DIRECTLY THROUGH HEALTH NET

For coverage, go to
www.myhealthnetca.com
to apply today!

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.

Health Net Individual & Family Coverage for You and Your Family

Is an Ambetter PPO Plan right for you?

When you enroll in the Ambetter PPO Plan, you choose your own doctors and Hospitals for all your health care needs. Ambetter PPO offers two different ways to access care:

- In-network - You choose a contracted doctor (or Hospital) within our Ambetter PPO network. You can take advantage of reduced out of pocket costs when you receive care from a provider who is contracted with Health Net for the Ambetter PPO plans.
- Out-of-network - You choose a doctor (or Hospital) outside of our Ambetter PPO network. These providers do not have a contract with Health Net for the Ambetter PPO plans. You will incur higher out-of-pocket costs than when you see a provider within our Ambetter PPO Network.

Except for Emergency Services and Care, when you choose to see an Out-of-Network Provider, you will pay the cost-sharing for the out-of-network benefit level, which is typically higher than the in-network benefit level. Plus, you are responsible for the difference between the amount the Out-of-Network Provider bills and the Maximum Allowable Amount (MAA). See the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" below for more details.

Except for Urgently Needed Care and Emergency Services and Care, services and supplies provided by providers outside of California are not covered.

Your choice of doctors and Hospitals may determine which services will be covered, as well as how much you will pay. Providers who are contracted with Health Net for the Ambetter PPO plans are called "Preferred Providers" or "Participating Providers" and they are listed on our website at www.myhealthnetca.com. You can also call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the Health Net Ambetter PPO Preferred Provider Directory at no cost.

In some instances, Prior Authorization (also known as pre-authorization or treatment review) is required for full benefits to be paid. Refer to the "Prior Authorization Requirements" section below to find out which services or supplies require authorization.

We believe maintaining an ongoing relationship with a Physician who knows you well and whom you trust is an important part of a good health care program. That's why with Ambetter PPO, you are required to select a Primary Care Physician (PCP) for yourself and each Member of your family, even though you may go directly to any provider without first seeing your PCP. When selecting a PCP, choose a participating Physician close enough to your residence to allow reasonable access to medical care. Information on how to select a PCP and a listing of the participating Physician 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. PCPs include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

Some of the Covered Expenses under the Ambetter PPO Plan are subject to a requirement of Prior Authorization in order for a non-authorization penalty to not apply. See the "Prior Authorization Requirements" below.

Calendar year deductible

For some Ambetter PPO plans, a Calendar Year Deductible is required for certain services 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. Any amount applied toward the Calendar Year Deductible for Covered Benefits received from a Preferred Provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Benefits received from an Out-of-Network Provider will not apply toward the Calendar Year Deductible for Preferred Providers. If your Plan has a Calendar Year Deductible, that Deductible does not apply to adult dental and vision services benefits under the Ambetter PPO 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 Ambetter PPO 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 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 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. Any Deductible, Copayments or Coinsurance paid for the services of a Preferred Provider will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductible, Copayments, or Coinsurance paid for the services of an Out-of-Network Provider will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments for adult dental and vision services benefits under the Ambetter PPO Plus plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" below) do not accrue toward your OOPM. For the Ambetter PPO plans, penalties paid for services which were not authorized as required do not apply to the yearly OOPM (see the "Prior Authorization Requirements" below). 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.

Prior Authorization Requirements

For Ambetter PPO plans, certain Covered Benefits require Health Net's review and approval, called authorization, before they are obtained. If these services are not authorized before they are received, you will be responsible for paying a $250 non-authorization penalty for in-network providers and a $500 non-authorization penalty for Out-of-Network Providers. These penalties do not apply to your Out-of-Pocket Maximum. **We may revise the Prior Authorization list from time to time. Any such changes including additions and deletions from the Prior Authorization list will be communicated to Participating Providers and posted on the www.myhealthnetca.com website.** ***Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules, and benefit limitations will still apply.*** See the Individual & Family *Plan Contract and EOC* for details.

Services that require authorization include:

Inpatient facility admissions[1]

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Behavioral health facility
- Hospice
- Hospital
- Skilled Nursing Facility
- Substance abuse facility

Outpatient procedures, services, or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
- Acupuncture (after the initial consultation, continued treatment plans may need approval from ASH)
- Ambulance: non-emergency air or ground ambulance services
- Bariatric procedures
- Bronchial thermoplasty
- Capsule Endoscopy
- Cardiovascular procedures
- Clinical Trials

- Diagnostic procedures including:
  1. Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
  2. Cardiac Imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Multigated Acquisition (MUGA) scan
     - Myocardial Perfusion Imaging (MPI)
  3. Sleep studies (facility-based sleep testing)
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/Investigational Services and new technologies.
- Gender affirming services
- Interventional Pain management
  1. Facet joint denervation, injection or block
  2. Epidural spine injections
  3. Sacroiliac (SI joint injection
  4. Spinal cord stimulator
  5. Sympathetic nerve block
- Mental Health or Substance Use Disorder services other than office visits including
  1. Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
  2. Electroconvulsive Therapy (ECT)
  3. Half-Day Partial Hospitalization
  4. Intensive Outpatient Program (IOP)
  5. Neuropsychological testing
  6. Partial Hospital Program or Day Hospital (PHP)
  7. Psychological testing
  8. Transcranial Magnetic Stimulation (TMS)
- Musculoskeletal procedures
  1. Joint surgery
  2. Spine surgery
- Neuro stimulator
- Neuropsychological Testing
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made items)
- Pharmaceuticals
  1. Outpatient Prescription Drugs
     - Most specialty drugs, including self-injectable drugs and hemophilia factors, must have Prior Authorization through the Prescription Drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Ambetter from Health Net Drug List to identify which drugs require Prior Authorization. Urgent or emergent drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.
     - Other Prescription Drugs, as indicated in the Ambetter from Health Net Drug List, may require Prior Authorization. Refer to the Ambetter from Health Net Drug List to identify which drugs require Prior Authorization.
  2. Certain Physician -administered drugs, including newly approved drugs, whether administered in a Physician office, free-standing infusion center, home-infusion, Outpatient Surgical Center, outpatient dialysis center, or outpatient Hospital. Refer to the Health Net website, www.myhealthnetca.com, for a list of Physician -administered drugs that require Prior Authorization. Biosimilars are required in lieu of branded drugs, unless Medically Necessary.
- Proprietary laboratory analysis
- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services, and supplies such as:
  1. Bone alteration or reshaping such as osteoplasty
  2. Breast reductions and augmentations except when following a mastectomy (includes mastectomy for gynecomastia)
  3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
  4. Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
  5. Excision, excessive skin, and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas

6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
8. Hair electrolysis, transplantation, or laser removal
9. Lift such as arm, body, face, neck, thigh
10. Liposuction
11. Nasal surgery such as rhinoplasty or septoplasty
12. Otoplasty
13. Penile implant
14. Treatment of varicose veins
15. Vermilionectomy with mucosal advancement

- Testosterone therapy
- Therapy (includes home setting)
  1. Occupational therapy
  2. Physical therapy
  3. Speech therapy
- Transplant and related services
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vestibuloplasty
- Wound care

[1]Prior authorization is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Prior Authorization is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery.

Maximum Allowable Amount (MAA) for Out-of-Network Providers

When you receive care from an Out-of-Network Provider, your share of cost is based on MAA. You are responsible for any applicable Deductible, Copayments or Coinsurance payment, **and** any amounts billed in excess of MAA. You are completely financially responsible for care that this Plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Health Net calculates MAA as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth below. MAA is not the amount that Health Net pays for a Covered Benefit; the actual payment will be reduced by applicable Deductibles, Copayments or Coinsurance and other applicable amounts set forth in the *Plan Contract and EOC*.

MAA for Covered Benefits, excluding Emergency Services and Care and outpatient pharmaceuticals, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare allowable amount.

For illustration purposes only, Out-of-Network Provider: 70% Health Net Payment, 30% member Coinsurance:

Out-of-network provider's billed charge for extended office visit	$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount)	$102.40
Your Coinsurance is 30% of MAA: 30% x $102.40 **(assumes deductible has already been satisfied)**	$30.72
You also are responsible for the difference between the billed charge ($128.00) and the MAA amount ($102.40)	$25.60
TOTAL AMOUNT OF $128.00 CHARGE THAT IS YOUR RESPONSIBILITY	**$56.32**

MAA for facility services, including but not limited to hospital, skilled nursing facility, and outpatient surgery, is determined by applying 150% of the Medicare allowable amount.

MAA for physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare allowable amount.

In the event there is no Medicare allowable amount for a billed service or supply code:

a. MAA for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with

Preferred Providers within the geographic region for the same Covered Benefits provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare allowable amount for the same Covered Benefits under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Benefits. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. MAA for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Benefits provided; (2) 100% of the derived amount using a proprietary method; (3) 150% of the Medicare allowable amount for the same Covered Benefits under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Benefits.

MAA for Out-of-Network Emergency Services and Care (Facility Services)

a. ***Facility services received within California*** will be determined as follows: (1) Health Net's proprietary reimbursement methodology, which is based on a cost-to-charge ratio, excluding any in-network Deductible, Copayment or Coinsurance; or, if a rate cannot be determined then, (2) the amount calculated using the same method Health Net generally uses to determine payments for Out-of-Network Providers, excluding any in-network Deductible, Copayment or Coinsurance; or if a rate cannot be determined then, (3) a percentage of billed charges. Emergency Services and Care at an Out-of-Network facility are subject to the applicable Deductible, Copayment and/or Coinsurance at the Preferred Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Services and Care.

b. ***Facility services received outside of California*** will be determined as follows: (1) the median Contracted Rate for the same or similar item or service in a specific geographic area; or, if a rate cannot be identified then, (2) the cost to charge ratio multiplied by billed charges; or, if a rate cannot be identified, then (3) a percentage of billed charges. Emergency Services and Care provided at an Out-of-Network facility are subject to the applicable Deductible, Copayment and/or Coinsurance at the Participating Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Services and Care.

Maximum Allowable Amount for Out-of-Network Emergency Services and Care (Professional Services)

a. ***Professional services received within California*** will be determined as follows: (1) the amount calculated using the same method Health Net generally uses to determine payments for Out-of-Network providers, excluding any in-network Deductible, Copayment or Coinsurance; or, if a rate cannot be identified, then (2) the 50th percentile of FAIR Health database of professional and ancillary services; or, if a rate cannot be identified, then (3) a percentage of billed charges. Emergency Services and Care from an Out-of-Network Provider is subject to the applicable Deductible, Copayment and/or Coinsurance at the Preferred Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Services and Care.

b. ***Professional services received outside of California*** will be determined as follows: (1) the median Contracted Rate for the same or similar item or service in a specific geographic area; or, if a rate cannot be identified then, (2) a percentage of billed charges. Emergency Services and Care provided at an Out-of-Network facility are subject to the applicable Deductible, Copayment and/or Coinsurance at the Participating Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Services and Care.

MMA for non-emergent services at an in-network health facility, at which, or as a result of which, You receive non-emergent Covered Benefits by an Out-of-Network Provider, the non-emergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.

MAA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

MAA for pediatric dental services is calculated by Health Net based on available data resources of competitive fees in that geographic area and must not exceed the fees that the dental provider would charge any similarly situated payor for the same services for each covered dental service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. Health Net reimburses nonnetwork dental providers at 55% of FAIR Health rates. You must pay the amount by which the nonnetwork provider's billed charge exceeds the eligible dental expense.

The MAA may also be subject to other limitations on Covered Expenses. See the Plan's EOC for specific benefit limitations, maximums, Prior Authorization requirements and payment policies that limit the amount Health Net pays for certain Covered Benefits. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("third-party networks"). In the event Health Net contracts with a third-party network that has a contract with the Out-of-Network Provider, Health Net may, at its option, use the rate agreed to by the third-party network as the MAA. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the MAA for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, you will not be responsible for the difference between billed charges and the MAA. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the out-of-network benefit level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare allowable amount, Health Net will adjust, without notice, the MAA based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if you wish to confirm the Covered Expenses for any treatment or procedure you are considering.

Timely Access to Care to Preferred Providers

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. Providers within the Ambetter PPO network agree to provide timely access to care.

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 Ambetter PPO 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)*

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 PPO Plus plans. A Health Net "Plus" plan is a Health Net Ambetter PPO 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.

*Dental and vision benefits for PPO plans are 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.

Platinum 90 Ambetter PPO

The Platinum 90 Ambetter PPO health Plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and emergency care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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 ("PLAN CONTRACT AND EOC")* AND SCHEDULE OF BENEFITS 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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	None	$5,000 single / $10,000 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$5,500 single / $11,000 family	$25,000 single / $50,000 family
Professional services Office visit	$20	50% after Deductible
Telehealth consultation through the Select Telehealth Services Provider[6]	$0	Not covered
Specialist consultation	$45	50% after Deductible
Medically necessary acupuncture	$20	Not covered
Preventive Care Services[7]	$0	Not covered
X-ray and diagnostic imaging	$35	50% after Deductible
Laboratory procedures	$25	50% after Deductible
Imaging (CT/PET scans, MRIs)	15%	50% after Deductible
Rehabilitation and habilitation therapy	$20	Not covered
Outpatient services Outpatient surgery	10%	50% after Deductible
Hospital services Inpatient hospital facility services (includes maternity)	10%	50% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	10%	50% after Deductible
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: $225; Physician: $0	Facility: $225; Physician: $0 (Deductible waived)
Urgent care	$20	50% after Deductible
Ambulance services (ground and air)	$150	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	10%	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $20 Other than office visit: 10% up to $20	50% after Deductible
Home health care services (100 visits/year)	10%	Not covered
Other services Durable medical equipment	10%	Not covered
Hospice service	$0	50% after Deductible

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription coverage[8] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	$0	Not covered
Tier 1 (most generics and low-cost preferred brands)	$10	Not covered
Tier 2 (non-preferred generics and preferred brands)	$25	Not covered
Tier 3 (non-preferred brands)	$45	Not covered
Tier 4 (Specialty drugs)	10% up to $250 per script	Not covered
Pediatric dental[9, 10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9, 11] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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]Certain services require Prior Authorization from Health Net. Without Prior Authorization, an additional $250 is applied for in-network providers, and $500 is applied for Out-of-Network Providers. Refer to the *Plan Contract and EOC* for details.

[2]Member pays Coinsurance based on the negotiated rate, which is the rate participating or Preferred Providers have agreed to accept for providing a Covered Benefit.

[3]Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

[4]Any amount applied toward the Calendar Year Deductible for Covered Benefits received from an in-network provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers.

[5]Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[6]You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[7]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.

[8]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 Physician s 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. 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.

[9]Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

[10]The pediatric dental benefits are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

[11]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 PPO 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. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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Gold 80 Ambetter PPO

The Gold 80 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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 ("PLAN CONTRACT AND EOC")* AND SCHEDULE OF BENEFITS 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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	None	$5,000 single / $10,000 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$9,600 single / $19,200 family	$25,000 single / $50,000 family
Professional services Office visit	$40	50% after Deductible
Telehealth consultation through the Select Telehealth Services Provider[6]	$0	Not covered
Specialist consultation	$80	50% after Deductible
Medically necessary acupuncture	$40	Not covered
Preventive Care Services[7]	$0	Not covered
X-ray and diagnostic imaging	$85	50% after Deductible
Laboratory procedures	$40	50% after Deductible
Imaging (CT/PET scans, MRIs)	25%	50% after Deductible
Rehabilitation and habilitation therapy	$40	Not covered
Outpatient services Outpatient surgery	30%	50% after Deductible
Hospital services Inpatient hospital facility services (includes maternity)	30%	50% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30%	50% after Deductible
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: $350; Physician: $0	Facility: $350; Physician: $0
Urgent care	$40	50% after Deductible
Ambulance services (ground and air)	$250	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	30%	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $40 Other than office visit: 20% up to $40	50% after Deductible
Home health care services (100 visits/year)	20%	Not covered
Other services Durable medical equipment	20%	Not covered
Hospice service	$0	50% after Deductible

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[8] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	$0	Not covered
Tier 1 (most generics and low-cost preferred brands)	$19	Not covered
Tier 2 (non-preferred generics and preferred brands)	$60	Not covered
Tier 3 (non-preferred brands)	$90	Not covered
Tier 4 (Specialty drugs)	20% up to $250 per script	Not covered
Pediatric dental[9, 10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9, 11] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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[1]Certain services require Prior Authorization from Health Net. Without Prior Authorization, an additional $250 is applied for in-network providers, and $500 is applied for Out-of-Network Providers. Refer to the *Plan Contract and EOC* for details.

[2]Member pays Coinsurance based on the negotiated rate, which is the rate participating or Preferred Providers have agreed to accept for providing a Covered Benefit.

[3]Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

[4]Any amount applied toward the Calendar Year Deductible for Covered Benefits received from an in-network provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers.

[5]Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[6]You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[7]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.

[8]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 Physician s 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. 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.

[9]Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

[10]The pediatric dental benefits are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

[11]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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Silver 70 Off Exchange Ambetter PPO

The Silver 70 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	$4,700 single / $9,400 family	$10,400 single / $20,800 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$11,650 single / $23,300 family	$25,000 single / $50,000 family
Professional services Office visit	$50	50%
Telehealth consultation through the Select Telehealth Services Provider[6]	$0	Not covered
Specialist consultation	$100	50%
Medically necessary acupuncture	$50	Not covered
Preventive Care Services[7]	$0	Not covered
X-ray and diagnostic imaging	$95	50%
Laboratory procedures	$50	50%
Imaging (CT/PET scans, MRIs)	$325	50%
Rehabilitation and habilitation therapy	$50	Not covered
Outpatient services Outpatient surgery	30%	50%
Hospital services Inpatient hospital facility services (includes maternity)	Facility: 30% after Deductible[8] Physician: 30%	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30% after Deductible	50%
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: $400; Physician: $0	Facility: $400; Physician: $0
Urgent care	$50	50% after Deductible
Ambulance services (ground and air)	$255	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services[8] Mental/Behavioral health/Substance use disorder (inpatient)	30% after Deductible	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $50 Other than office visit: $0	50% after Deductible
Home health care services (100 visits/year)	$45	Not covered
Other services Durable medical equipment	20%	Not covered
Hospice service	$0	50% after Deductible

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[9] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	$50 single / $100 family	Not covered
Tier 1 (most generics and low-cost preferred brands)	$20	Not covered
Tier 2 (non-preferred generics and preferred brands	$65 after Rx Deductible	Not covered
Tier 3 (non-preferred brands)	$95 after Rx Deductible	Not covered
Tier 4 (Specialty drugs)	20% up to $250 per script after Rx Deductible	Not covered
Pediatric dental[10, 11] Diagnostic and preventive services	$0	Not covered
Pediatric vision[10, 12] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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.

Certain services require Prior Authorization from Health Net. Without Prior Authorization, an additional $250 is applied for in-network providers, and $500 is applied for Out-of-Network Providers. Refer to the *Plan Contract and EOC* for details.

[1] Member pays Coinsurance based on the negotiated rate, which is the rate participating or Preferred Providers have agreed to accept for providing a Covered Benefit.

[2] Please refer to the Plan Contract and EOC for out-of-network reimbursement methodology.

[3] Any amount applied toward the Calendar Year Deductible for Covered Benefits received from an in-network provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers.

[4] Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[5] You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[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] If a Hospital does not bill charges for inpatient professional services separately from the inpatient facility fee, the Deductible will apply.

[8] 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 Physician s 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. 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.

[9] Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

[10] The pediatric dental benefits are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net of California, Inc. See the Plan Contract and EOC for pediatric dental benefit details.

[11] 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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Bronze 60 Ambetter PPO

The Bronze 60 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for covered benefits and services. For a lower cost-share, please make sure you use providers (doctors, hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available through Covered CA in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	$5,800 single / $11,600 family	$11,600 single / $23,200 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$11,650 single / $23,300 family	$25,000 single / $50,000 family
Professional services Office visit	$60	50% after Deductible
Telehealth consultation through the Select Telehealth Services Provider[7]	$0	Not covered
Specialist consultation	Visits 1–3: $100 / Visits 4+: $100[6]	50% after Deductible
Medically necessary acupuncture	$60	Not covered
Preventive Care Services[8]	$0	Not covered
X-ray and diagnostic imaging	40% after Deductible[9]	50% after Deductible
Laboratory procedures	$50	50% after Deductible
Imaging (CT/PET scans, MRIs)	40% after Deductible[9]	50% after Deductible
Rehabilitation and habilitation therapy	$60	Not covered
Outpatient services Outpatient surgery	40% after Deductible[9]	50% after Deductible
Hospital services Inpatient hospital facility services (includes maternity)	40% after Deductible[9]	50% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	40% after Deductible[9]	50% after Deductible
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: 40% after Deductible[9]; Physician: $0	Facility: 40% after Deductible[9]; Physician: $0
Urgent care	$60	50% after Deductible
Ambulance services (ground and air)	40% after Deductible[9]	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services[9] Mental/Behavioral health/Substance use disorder (inpatient)	40% after Deductible[9]	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $60 Other than office visit: 40% up to $60	50% after Deductible
Home health care services (100 visits/year)	40% after Deductible[9]	Not covered
Other services Durable medical equipment	40% after Deductible[9]	Not covered
Hospice service	$0	50% after Deductible

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[10] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	$450 single / $900 family	Not covered
Tier 1 (most generics and low-cost preferred brands)	$20 per script	Not covered
Tier 2 (non-preferred generics and preferred brands	40% up to $500 per script after Rx Deductible[11]	Not covered
Tier 3 (non-preferred brands)	40% up to $500 per script after Rx Deductible[11]	Not covered
Tier 4 (Specialty drugs)	40% up to $500 per script after Rx Deductible[11]	Not covered
Pediatric dental[12, 13] Diagnostic and preventive services	$0	Not covered
Pediatric vision[12, 14] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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] Certain services require prior authorization from Health Net. Without prior authorization, an additional $250 is applied for in-network providers, and $500 is applied for out-of-network providers. Refer to the *Plan Contract and EOC* for details.

[2] Member pays coinsurance based on the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers.

[5] Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[6] The Calendar Year Deductible applies after the first 3 non-preventive Specialist visits.

[7] You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[8] 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.

[9] After the medical Deductible has been reached, the Member is responsible for 40% of the eligible charges until their out-of- pocket maximum limit is met. For in-network benefits, eligible charges are the negotiated rate. For out-of-network emergency room and emergency medical transportation, eligible charges are the allowed charges and are subject to the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum.

[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 Physician s 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. 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.

[11] After the pharmacy Deductible has been reached, the Member will be responsible for 40% of the cost of all Tier 2, 3, and 4 drugs up to a maximum payment of $500 for each prescription of up to a 30-day supply, until the Out-of-Pocket Maximum limit is met.

[12] Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

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

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(1/1/27)

Bronze 60 HDHP Ambetter PPO

The Bronze 60 HDHP Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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 ("PLAN CONTRACT AND EOC")* AND SCHEDULE OF BENEFITS 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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	$7,800 single / $15,600 family	$15,600 single / $31,200 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$7,800 single / $15,600 family	$25,000 single / $50,000 family
Professional services Office visit	0% after Deductible	50% after Deductible
Telehealth consultation through the Select Telehealth Services Provider[6]	$0	Not covered
Specialist consultation	0% after Deductible	50% after Deductible
Medically necessary acupuncture	0% after Deductible	Not covered
Preventive Care Services[7]	$0	Not covered
X-ray and diagnostic imaging	0% after Deductible	50% after Deductible
Laboratory procedures	0% after Deductible	50% after Deductible
Imaging (CT/PET scans, MRIs)	0% after Deductible	50% after Deductible
Rehabilitation and habilitation therapy	0% after Deductible	Not covered
Outpatient services Outpatient surgery	0% after Deductible	50% after Deductible
Hospital services Inpatient hospital facility services (includes maternity)	0% after Deductible	50% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0% after Deductible	50% after Deductible
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: 0% after Deductible; Physician: $0 after Deductible	Facility: 0% after Deductible; Physician: $0 after Deductible
Urgent care	0% after Deductible	50% after Deductible
Ambulance services (ground and air)	0% after Deductible	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services[7] Mental/Behavioral health/Substance use disorder (inpatient)	0% after Deductible	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: 0% after Deductible Other than office visit: 0% after Deductible	50% after Deductible
Home health care services (100 visits/year)	0% after Deductible	Not covered
Other services Durable medical equipment	0% after Deductible	Not covered
Hospice service	0% after Deductible	50% after Deductible

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[8] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	Integrated with medical Deductible	Not covered
Tier 1 (most generics and low-cost preferred brands)	0% after medical Deductible	Not covered
Tier 2 (non-preferred generics and preferred brands	0% after medical Deductible	Not covered
Tier 3 (non-preferred brands)	0% after medical Deductible	Not covered
Tier 4 (Specialty drugs)	0% after medical Deductible	Not covered
Pediatric dental[9, 10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9, 11] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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[1]Certain services require Prior Authorization from Health Net. Without Prior Authorization, an additional $250 is applied for in-network providers, and $500 is applied for Out-of-Network Providers. Refer to the *Plan Contract and EOC* for details.

[2]Member pays Coinsurance based on the negotiated rate, which is the rate participating or Preferred Providers have agreed to accept for providing a Covered Benefit.

[3]Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

[4]Any amount applied toward the Calendar Year Deductible for Covered Benefits received from an in-network provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers.

[5]Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[6]You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[7]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.

[8]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 Physician s 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. 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.

[9]Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

[10]The pediatric dental benefits are provided by Health Net of California, Inc. and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

[11]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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(1/1/27)

Minimum Coverage Ambetter PPO

The Minimum Coverage Ambetter PPO health Plan utilizes the **Ambetter PPO** provider network for Covered Benefits and services. For a lower cost-share, please make sure you use providers (doctors, Hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available directly through Health Net in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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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 (also called Coinsurance) 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	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a Deductible unless noted.		
Plan maximums Calendar year deductible[4]	$12,000 single / $24,000 family	$24,000 single / $48,000 family
Out-of-Pocket Maximum (includes Calendar Year Deductible)[5]	$12,000 single / $24,000 family	$25,000 single / $50,000 family
Professional services Office visit	Visits 1-3: 0% / Visits 4+: 0% after Deductible[6]	50% after Deductible
Telehealth consultation through the Select Telehealth Services Provider[7]	$0	Not covered
Specialist consultation	0%	50% after Deductible
Medically necessary acupuncture	Visits 1-3: 0% (Deductible waived) / Visits 4+: 0% after Deductible[6]	Not covered
Preventive Care Services[8]	$0	Not covered
X-ray and diagnostic imaging	0% after Deductible	50% after Deductible
Laboratory procedures	0% after Deductible	50% after Deductible
Imaging (CT/PET scans, MRIs)	0% after Deductible	50% after Deductible
Rehabilitation and habilitation therapy	0% after Deductible	Not covered
Outpatient services Outpatient surgery	0% after Deductible	50% after Deductible
Hospital services Inpatient hospital facility services (includes maternity)	0% after Deductible	50% after Deductible
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0% after Deductible	50% after Deductible
Emergency services and care Emergency room (Copayment waived if admitted)	Facility: 0% after Deductible; Physician: $0	Facility: 0% after Deductible; Physician: $0
Urgent care	Office visit: Visits 1-3: 0% / Visits 4+: 0% after Deductible[6]	50% after Deductible
Ambulance services (ground and air)	0% after Deductible	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/Substance use disorder services[8] Mental/Behavioral health/Substance use disorder (inpatient)	0% after Deductible	50% after Deductible
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: Visits 1-3: 0% / Visits 4+: 0% after Deductible[6] Other than office visit: 0% after Deductible	50% after Deductible
Home health care services (100 visits/year)	0% after Deductible	Not covered

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Other services Durable medical equipment	0% after Deductible	Not covered
Hospice service	0% after Deductible	50% after Deductible
Prescription drug coverage[9] (up to a 30-day supply obtained through a participating pharmacy) Prescription Drug Calendar Year Deductible	Integrated with medical Deductible	Not covered
Tier 1 (most generics and low-cost preferred brands)	0% after medical Deductible	Not covered
Tier 2 (non-preferred generics and preferred brands	0% after medical Deductible	Not covered
Tier 3 (non-preferred brands)	0% after medical Deductible	Not covered
Tier 4 (Specialty drugs)	0% after medical Deductible	Not covered
Pediatric dental[10, 11] Diagnostic and preventive services	$0	Not covered
Pediatric vision[10, 12] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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[1] Certain services require prior authorization from Health Net. Without prior authorization, an additional $250 is applied for in-network providers, and $500 is applied for out-of-network providers. Refer to the *Plan Contract and EOC* for details.

[2] Member pays coinsurance based on the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to the *Plan Contract and EOC* for out-of-network reimbursement methodology.

[4] Any amount applied toward the calendar year deductible for covered services and supplies received from an in-network provider will not apply toward the calendar year deductible for out-of-network providers.

[5] Copayments or Coinsurance paid for in-network services will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers, and Coinsurance paid for out-of-network services will not apply toward the Out-of-Pocket Maximum for Preferred Providers. Copayments or Coinsurance for out-of-network Emergency Services and Care, including emergency room and ambulance services, accrues to the Out-of-Pocket Maximum for Preferred Providers.

[6] Minimum Coverage Plan: Visits 1–3 (combined between primary care office visits, urgent care, and other practitioner non-Physician provider office visits, including acupuncturists, outpatient mental health/substance abuse): The Calendar Year Deductible is waived. Visits 4–unlimited: The Calendar Year Deductible applies.

[7] You may receive services on an in-person basis or via telehealth, if available, from your primary care provider, 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 provider.

[8] 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.

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[10] Pediatric dental and vision are included up to the last day of the month in which the Member turns 19 years of age. Cost-sharing is applicable for non-diagnostic and preventive pediatric dental benefits.

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[12] 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.

Minimum Coverage Plans: Minimum coverage Plans are available to individuals who are under age 30. You may also be eligible for this Plan if you are age 30 or older and are exempt from the federal requirement to maintain minimum essential coverage. Once you are enrolled, you must re-apply for a hardship exemption from the Marketplace and re-submit the Marketplace notice showing your exemption certificate number to Health Net every year – by January 1 – in order to remain on this Plan.

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(1/1/27)

Important Things to Know About Your Medical Coverage

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 Doctor*. 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

Who is eligible?

To be eligible for a Health Net Ambetter Individual & Family (a) live in the Service Area; 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 (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 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 297 or 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 and EOC* 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 and EOC* 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 cancelled, you will be sent a notice of cancellation 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 Contract* 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 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 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 your health Plan, you should first telephone your health Plan at (**1-800-839-2172**) and use your health Plan's 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 your health Plan, 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 Services or Investigational Services 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 are Health Net's premium ratios?

Health Net's 2025 ratio of premium costs to health services paid for Individual & Family PPO Plans was 88.1%.

What is the relationship of the involved parties?

Physician groups, contracting Physician s, 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 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 of your Plan.

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

Health Net will make every effort to ensure that care continues. You may request continued care from an Out-of-Network Provider at the in-network benefit level if, at the time of contract termination, you were receiving care from such a provider for the conditions listed below. For providers and Hospitals that end their contract with Health Net, a written notice will be provided to Members with open authorizations within five days after the Effective Date of the contract termination.

If Health Net's contract with a Preferred Provider is terminated, Health Net may provide coverage for completion of services at the in-network benefit level from a provider whose contract has ended, subject to applicable Deductible, Copayments or Coinsurance and any other exclusions and limitations of your 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 it is reasonably possible.

The following conditions are eligible for continuation of care:

- 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.

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.

What about continuity of care if my coverage was terminated due to my health plan or health insurer no longer offering my health plan?

You may request continued care from a provider, including a Hospital, that does not contract with Health Net if your prior coverage was an individual Plan that was terminated due to the health Plan or health insurer no longer offering your health Plan and, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the Member's Effective Date of coverage under this Plan;
- 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 your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health Plan as part of a documented course of treatment.

Health Net may provide coverage for completion of services from an Out-of-Network Provider at the in-network benefit level, subject to applicable Copayments and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Effective Date unless you can show that it was not reasonably possible to make the request within 60 days of your Effective Date and you make the request as soon as reasonably possible. The Out-of-Network Provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider at the in-network benefit level.

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 the Customer Contact Center at the telephone number on 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, in Dependent 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 pays Preferred Providers on a fee-for-service basis, according to an agreed Contracted Rate. 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 and am I liable for payment of certain services?

Covered Benefits from Preferred Providers are paid at the in-network benefit level. The maximum amount of Covered Expenses for a service or supply provided by a Preferred Provider is the lesser of the billed charge or the Contracted Rate. You will not be responsible for any amount billed in excess of the Contracted Rate. However, you are responsible for any applicable Deductible, Copayments or Coinsurance payment. You are always responsible for services or supplies not covered by this Plan.

Under the out-of-network benefit level, you may receive medical care from any licensed Out-of-Network Provider. Out-of-Network Providers have not agreed to participate in the Health Net Ambetter PPO Network. Therefore, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of the Ambetter PPO *Plan Contract and EOC* for more details on how we determine MAA.

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

Health Net covers emergency and Urgently Needed Care throughout the world.

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

When Emergency Services and Care are provided by an Out-of-Network Provider: When Covered Benefits are received in connection with Emergency Services and Care, you will pay the in-network level of cost-sharing, regardless of whether the provider is an in-network or an Out-of-Network Provider, and without balance billing. Balance billing is the difference between an Out-of-Network Provider's billed charge and the Maximum Allowable Amount. When you receive Emergency Services and Care from an Out-of-Network Provider, your payment of the cost-sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for in-network providers.

For information regarding Health Net's payment for out-of-network Emergency Services and Care, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section.

If your situation is not so severe: This Plan covers care from in-network providers and Out-of-Network Providers. You do not need a referral. You can also call 988, the national suicide and mental health crisis hotline system. **WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.** This is because the cost-sharing for the out-of-network benefit is typically higher than for the in-network benefit. Plus, you are responsible for the difference between the amount the Out-of-Network Provider bills and the Maximum Allowable Amount (MAA).

Emergency Services and 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 Services and 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*.

If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating Health Care Provider at the Hospital believes that you require additional Medically Necessary Hospital services, the Hospital must contact Health Net to obtain timely Prior Authorization, or you will be subject to the non-authorization penalty. If you want to be transferred from an out-of-network Hospital to a Preferred Provider Hospital, and Health Net determines that you may be safely transferred, Health Net will arrange for the transfer and for the care to continue at the Preferred Provider Hospital.

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

Out-of-Network Providers may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net for a determination of what portion of the billed charges is reimbursable to you.

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 and EOC*.

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 or experimental, 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 *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 Physician s and community resources.



Additional Product Information

Mental health or substance use disorders

You may obtain Mental Health or Substance Use Disorder services from any behavioral health provider. To obtain care at the in-network benefit level, contact the Health Net Customer Contact Center at the phone number on the back cover. Health Net will help you identify a nearby participating behavioral health professional 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/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 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.

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

You must purchase covered drugs at a Participating Pharmacy in the Health Net Ambetter Pharmacy Network except for emergency or Urgently Needed Care. Not all pharmacies that contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency or Urgently Needed Care, 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 out-of-network pharmacies under this Plan.

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.

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.

Prescription Drug Deductible

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.

Preventive Drugs

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.

Over-the-counter preventive drugs, except for over-the-counter contraceptives, which are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs. Over-the-counter contraceptives that are covered under this Plan do not require a Prescription Drug Order but must be obtained from a Health Net Participating Pharmacy at the Prescription Drug counter.

Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are 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.

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. 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 Health Net Ambetter from 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 Health Net Ambetter from 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. 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.

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 from Health Net Drug List, it ensures that you are receiving a high-quality prescription medication that is also of high value.

The Ambetter from 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 Physician s 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 from 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 from 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 from Health Net Drug List to determine whether or not a particular drug is covered.

Tier 3 drugs

Tier 3 Drugs include non-preferred 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)

Tier 4 Drugs (Specialty Drugs) are specific Prescription 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 from Health Net Drug List with "SP." Refer to Health Net's Ambetter from 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 PPO 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 from 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" section in the *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 or step therapy. 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 or step therapy, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. The Ambetter from Health Net Drug List identifies which drugs require Prior Authorization or step therapy. You may obtain a list of drugs requiring Prior Authorization or step therapy by visiting our website at **www.myhealthnetca.com** or contact the Health Net Customer Contact Center at the phone number on the back cover. Step therapy exceptions are also subject to the Prior Authorization process.

The criteria used for Prior Authorization or step therapy 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.

Urgent requests from Physician s 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 Physician s 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.

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 or 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 Services 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. 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.
- 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 nonprescription 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 or investigational 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 from 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 *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

We provide toll-free access to our customer service to assist you with benefit coverage questions, resolving problems or changing your vision office. Customer service can be reached at (866) 392-6058 **Monday-Saturday, 5:00 a.m. to 8:00 p.m. and Sunday, 8:00 a.m. to 5:00 p.m.** Pacific Standard Time. Automated service is also provided after hours for eligibility verification and vision office transfers.

All of the following services must be provided by a Health Net participating vision provider in order to be covered. Refer to the "Pediatric Vision Services" portion of the "Exclusions and Limitations" section for limitations on covered vision services.

The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Pediatric vision care

Vision Services Benefits	Copayment
Routine eye exam limit: 1 per calendar year **Exam options:** • Standard contact lens fit including follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions) • Premium contact lens fit including follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)	$0 Copayment, Deductible waived
Lenses limit: 1 pair per calendar year Including: • Single vision, bifocal, trifocal, lenticular • Glass, or plastic, including polycarbonate	$0 Copayment, Deductible waived
Provider selected frames limit: 1 per calendar year	$0 Copayment, Deductible waived
Optional lenses and treatments Including: • UV treatment • Tint (fashion & gradient & glass-grey) • Standard plastic scratch coating • Photochromic / transitions plastic • Standard and premium anti-reflective coating • Polarized • Standard and premium progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses	$0 Copayment, Deductible waived
Provider selected contact lenses, a one year supply is covered every calendar year (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[1]	$0 Copayment, Deductible waived
Subnormal or low vision services and aids – supplemental testing, follow-up care, and low vision aids	$0 Copayment, Deductible waived

[1]Medically Necessary Contact Lenses:

Contact lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

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.

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:

- Covered Benefits provided by a provider who is not a participating vision provider
- Orthoptic or vision training;
- 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.
- Medical and/or surgical treatment of the eye, eyes or supporting structures; however, this is covered under the medical benefit;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date a Member ceases to be covered under the *Plan Contract and EOC*, except when vision materials ordered before coverage ended are delivered,
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

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

Pediatric dental services

All of the following services must be provided by a Health Net Participating 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 services and or cost sharing as described in your supplemental pediatric dental benefit Plan coverage document.

If there are no network dental providers available within the access standards for a given zip code, the Member can ask to see an out-of-network dental provider at the in-network cost share by calling Member services at **(866) 249-2382**. If we determine that an in-network dental provider is not within the access standards for your zip code, the Plan will verbally approve the request during the Member services call and the Member will only be responsible for the in-network dental cost share.

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 PPO 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 PPO Minimum Coverage Plan, your copay is $0 for the noted Covered Benefits for the remainder of the Calendar Year.

Benefit Description

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Code	Service	Member cost share
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 periapicals 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). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12-month period.	No charge
D0230	X-rays intraoral – periapical each additional film limited to a maximum of 20 periapicals in a 12-month period	No charge
D0240	X-rays iIntraoral – 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
D0470	Diagnostic casts	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

Code	Service	Member cost share
Preventive		
D1110	Prophylaxis – adult limited to once in a 12-month period	No charge
D1120	Prophylaxis – child limited to once in a 6-month period	No charge
D1206	Topical fluoride varnish limited to once in a 6-month period	No charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6-month period	No charge
D1310	Nutritional counseling for control of dental disease	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	20%
D2140	Amalgam – one surface, permanent limited to once in a 36-month period	20%
D2150	Amalgam – two surfaces, primary limited to once in a 12-month period	20%
D2150	Amalgam – two surfaces, permanent limited to once in a 36-month period	20%
D2160	Amalgam – three surfaces, primary limited to once in a 12-month period	20%
D2160	Amalgam – three surfaces, permanent limited to once in a 36-month period	20%
D2161	Amalgam – four or more surfaces, primary limited to once in a 12-month period	20%
D2161	Amalgam – four or more surfaces, permanent limited to once in a 36-month period	20%
D2330	Resin–based composite – one surface, anterior, primary limited to once in a 12-month period	20%
D2330	Resin–based composite – one surface, anterior, permanent limited to once in a 36-month period	20%
D2331	Resin–based composite – two surfaces, anterior primary limited to once in a 12-month period	20%
D2331	Resin–based composite – two surfaces, anterior permanent limited to once in a 36-month period	20%
D2332	Resin–based composite – three surfaces, anterior primary limited to once in a 12-month period	20%
D2332	Resin–based composite – three surfaces, anterior permanent limited to once in a 36-month period	20%
D2335	Resin–based composite – four or more surfaces (anterior) primary limited to once in a 12-month period	20%
D2335	Resin–based composite – four or more surfaces (anterior) permanent limited to once in a 36-month period	20%
D2390	Resin–based composite crown, anterior, primary limited to once in a 12-month period	20%
D2390	Resin–based composite crown, anterior, permanent limited to once in a 36-month period	20%
D2391	Resin–based composite – one surface, posterior primary limited to once in a 12-month period	20%
D2391	Resin–based composite – one surface, posterior permanent limited to once in a 36-month period	20%
D2392	Resin–based composite – two surfaces, posterior; primary limited to once in a 12-month period	20%
D2392	Resin–based composite – two surfaces, posterior; permanent limited to once in a 36-month period	20%
D2393	Resin–based composite – three surfaces, posterior; primary limited to once in a 12-month period	20%
D2393	Resin–based composite – three surfaces, posterior; permanent limited to once in a 36-month period	20%

(continued)

Code	Service	Member cost share
D2394	Resin–based composite – four or more surfaces, posterior; primary limited to once in a 12-month period	20%
D2394	Resin–based composite – four or more surfaces, posterior; permanent limited to once in a 36-month period	20%
D2710	Crown – resin–based composite (indirect) limited to once in a 5 year period	50%
D2712	Crown – ¾ resin–based composite (indirect) limited to once in a 5 year period	50%
D2721	Crown – resin with predominantly base metal limited to once in a 5 year period	50%
D2740	Crown – porcelain/ceramic limited to once in a 5 year period	50%
D2751	Crown – porcelain fused to predominantly base metal limited to once in a 5 year period	50%
D2781	Crown – ¾ cast predominantly base metal limited to once in a 5 year period	50%
D2783	Crown – ¾ porcelain/ceramic limited to once in a 5 year period	50%
D2791	Crown – full cast predominantly base metal limited to once in a 5 year period	50%
D2910	Recement or re–bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period	20%
D2915	Recement or re–bond indirectly fabricated or prefabricated post and core	20%
D2920	Recement or re–bond crown	20%
D2921	Reattachment of tooth fragment, incisal edge or cusp	20%
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	20%
D2929	Prefabricated porcelain/ceramic crown – primary tooth limited to once in a 12-month period	20%
D2930	Prefabricated stainless steel crown – primary tooth limited to once in a 12-month period	20%
D2931	Prefabricated stainless steel crown – permanent tooth limited to once in a 36-month period	20%
D2932	Prefabricated resin crown, primary limited to once in a 12-month period	20%
D2932	Prefabricated resin crown, permanent limited to once in a 36-month period	20%
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12-month period	20%
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36-month period	20%
D2940	Placement of interim direct restoration limited to once per tooth in a 12-month period	20%
D2949	Restorative foundation for an indirect restoration	20%
D2950	Core buildup, including any pins when required	20%
D2951	Pin retention – per tooth, in addition to restoration	20%
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	20%
D2953	Each additional indirectly fabricated post – same tooth	20%
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	20%
D2955	Post removal	20%
D2957	Each additional prefabricated post – same tooth	20%
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	20%
D2976	Band stabilization – per tooth	20%
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.	20%
D2989	Excavation of a tooth resulting in the determination of non-restorability	20%
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge
D2999	Unspecified restorative procedure, by report	20%
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	50%
D3120	Pulp cap – indirect (excluding final restoration)	50%
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	50%
D3221	Pupal debridement primary and permanent teeth	50%
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	50%
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%

Code	Service	Member cost share
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3331	Treatment of root canal obstruction; non–surgical access	50%
D3333	Internal root repair of perforation defects	50%
D3346	Retreatment of previous root canal therapy – anterior	50%
D3347	Retreatment of previous root canal therapy – premolar	50%
D3348	Retreatment of previous root canal therapy – molar	50%
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	50%
D3352	Apexification/recalcification – interim medication replacement only following D3351. Limited to once per permanent tooth	50%
D3410	Apicoectomy – anterior	50%
D3421	Apicoectomy – premolar (first root)	50%
D3425	Apicoectomy – molar (first root)	50%
D3426	Apicoectomy (each additional root)	50%
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	50%
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	50%
D3430	Retrograde filling – per root	50%
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	50%
D3471	Surgical repair of root resorption – anterior	50%
D3472	Surgical repair of root resorption – premolar	50%
D3473	Surgical repair of root resorption – molar	50%
D3910	Surgical procedure for isolation of tooth with rubber dam	50%
D3999	Unspecified endodontic procedure, by report	50%
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36-months	50%
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	50%
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	50%
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	50%
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	50%
D4341	Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24-months	50%
D4342	Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24-months	50%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50%
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%
D4910	Periodontal maintenance limited to once in a calendar quarter	20%
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).	50%
D4999	Unspecified periodontal procedure, by report	50%
Prosthodontics, removable		50%
D5110	Complete denture – maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	50%
D5120	Complete denture – mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	50%
D5130	Immediate denture – maxillary	50%
D5140	Immediate denture – mandibular	50%

(continued)

Code	Service	Member cost share
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%
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	50%
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	50%
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	50%
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	50%
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5410	Adjust complete denture – maxillary limited to once per date of service; twice in a 12-month period	50%
D5411	Adjust complete denture – mandibular limited to once per date of service; twice in a 12-month period	50%
D5421	Adjust partial denture – maxillary limited to once per date of service; twice in a 12-month period	50%
D5422	Adjust partial denture – mandibular limited to once per date of service; twice in a 12-month period	50%
D5511	Repair broken complete denture base, mandibular	50%
D5512	Repair broken complete denture base, maxillary	50%
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	50%
D5611	Repair resin denture base, mandibular	50%
D5612	Repair resin denture base, maxillary	50%
D5621	Repair cast framework, mandibular	50%
D5622	Repair cast framework, maxillary	50%
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%
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	50%
D5650	Add tooth to existing partial denture – per tooth – limited to a maximum of three, per date of service; once per tooth	50%
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	50%
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period	50%
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period	50%
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period	50%
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period	50%
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period	50%
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period	50%
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period	50%
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period	50%
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period	50%
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.	50%
D5862	Precision attachment, by report	50%
D5863	Overdenture - complete maxillary – natural tooth borne	50%
D5864	Overdenture - partial maxillary – natural tooth borne	50%
D5865	Overdenture - complete mandibular – natural tooth borne	50%
D5866	Overdenture - partial mandibular – natural tooth borne	50%
D5899	Unspecified removable prosthodontic procedure, by report	50%
Maxillofacial Prosthetics		
D5909	Maxillary guidance prosthesis with guide flange	50%
D5911	Facial moulage (sectional)	50%

Code	Service	Member cost share
D5912	Facial moulage (complete)	50%
D5913	Nasal prosthesis	50%
D5914	Auricular prosthesis	50%
D5915	Orbital prosthesis	50%
D5916	Ocular prosthesis	50%
D5919	Facial prosthesis	50%
D5922	Nasal septal prosthesis	50%
D5923	Ocular prosthesis, interim	50%
D5924	Cranial prosthesis	50%
D5925	Facial augmentation implant prosthesis	50%
D5926	Nasal prosthesis, replacement	50%
D5927	Auricular prosthesis, replacement	50%
D5928	Orbital prosthesis, replacement	50%
D5929	Facial prosthesis, replacement	50%
D5930	Maxillary guidance prosthesis without guide flange	50%
D5931	Obturator prosthesis, surgical	50%
D5932	Obturator prosthesis, definitive	50%
D5933	Obturator prosthesis, modification limited to twice in a 12-month period	50%
D5934	Mandibular guidance prosthesis with guide flange	50%
D5935	Mandibular guidance prosthesis without guide flange	50%
D5936	Obturator prosthesis, interim	50%
D5937	Trismus appliance (not for TMD treatment)	50%
D5938	Resection prosthesis, maxillary complete removable	50%
D5939	Resection prosthesis, mandibular complete removable	50%
D5940	Resection prosthesis, maxillary partial removable	50%
D5941	Resection prosthesis, maxillary partial removable	50%
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	50%
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	50%
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	50%
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	50%
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	50%
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	50%
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	50%
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	50%
D5951	Feeding aid	50%
D5952	Speech aid prosthesis, pediatric	50%
D5953	Speech aid prosthesis, adult	50%
D5954	Palatal augmentation prosthesis	50%
D5955	Palatal lift prosthesis, definitive	50%
D5958	Palatal lift prosthesis, interim	50%
D5959	Palatal lift prosthesis, modification limited to twice in a 12-month period	50%
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period	50%
D5982	Surgical stent for soft tissue healing	50%
D5983	Radiation carrier	50%
D5984	Radiation shield	50%
D5985	Radiation cone locator	50%
D5986	Fluoride gel carrier	50%
D5987	Commissure splint	50%
D5988	Surgical splint	50%
D5991	Vesiculobullous disease medicament carrier	50%

(continued)

Code	Service	Member cost share
D5999	Unspecified maxillofacial prosthesis, by report	50%
Implant Services		50%
D6010	Surgical placement of implant body: endosteal implant	50%
D6011	Surgical access to an implant body (second stage implant surgery)	50%
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	50%
D6013	Surgical placement of mini implant	50%
D6040	Surgical placement: eposteal implant	50%
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	50%
D6050	Surgical placement: transosteal implant	50%
D6055	Connecting bar – implant supported or abutment supported	50%
D6056	Prefabricated abutment – includes modification and placement	50%
D6057	Custom fabricated abutment – includes placement	50%
D6058	Abutment supported porcelain/ceramic crown	50%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	50%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	50%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	50%
D6062	Abutment supported cast metal crown (high noble metal)	50%
D6063	Abutment supported cast metal crown (predominantly base metal)	50%
D6064	Abutment supported cast metal crown (noble metal)	50%
D6065	Implant supported porcelain/ceramic crown	50%
D6066	Implant supported crown (porcelain fused to high noble alloys)	50%
D6067	Implant supported crown (high noble alloys)	50%
D6068	Abutment supported retainer for porcelain/ceramic FPD	50%
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	50%
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	50%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	50%
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	50%
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	50%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	50%
D6075	Implant supported retainer for ceramic FPD	50%
D6076	Implant supported retainer FPD (porcelain fused to high noble alloys)	50%
D6077	Implant supported retainer for metal FPD (high noble alloys)	50%
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	50%
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	50%
D6082	Implant supported crown – porcelain fused to predominantly base alloys	50%
D6083	Implant supported crown – porcelain fused to noble alloys	50%
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	50%
D6085	Interim implant crown	50%
D6086	Implant supported crown – predominantly base alloys	50%
D6087	Implant supported crown – noble alloys	50%
D6088	Implant supported crown – titanium and titanium alloys	50%
D6089	Accessing and retorquing loose implant screw – per screw	50%
D6090	Repair of implant/abutment supported prosthesis	50%
D6091	Replacement of replaceable part of semi–precision or precision attachment of implant/abutment supported prosthesis, per attachment	50%
D6092	Recement implant/abutment supported crown	50%
D6093	Recement implant/abutment supported fixed partial denture	50%
D6094	Abutment supported crown – titanium and titanium alloys	50%

Code	Service	Member cost share
D6096	Removal of broken implant retaining screw	50%
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	50%
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	50%
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	50%
D6100	Surgical removal of implant body	50%
D6105	Removal of implant body not requiring bone removal or flap elevation	50%
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	50%
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	50%
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	50%
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	50%
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	50%
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	50%
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	50%
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	50%
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	50%
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	50%
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	50%
D6121	Implant supported retainer for metal FPD – predominantly base alloys	50%
D6122	Implant supported retainer for metal FPD – noble alloys	50%
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	50%
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	50%
D6190	Radiographic/Surgical implant index, by report	50%
D6191	Semi-precision abutment – placement	50%
D6192	Semi-precision attachment – placement	50%
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	50%
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	50%
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	50%
D6198	Remove interim implant component	50%
D6199	Unspecified implant procedure, by report	50%
Prosthodontics, fixed		50%
D6211	Pontic – cast predominantly base metal limited to once in a 5 year period	50%
D6241	Pontic – porcelain fused to predominantly base metal limited to once in a 5 year period	50%
D6245	Pontic – porcelain/ceramic limited to once in a 5 year period	50%
D6251	Pontic – resin with predominantly base metal limited to once in a 5 year period	50%
D6721	Retainer crown – resin predominantly base metal – denture limited to once in a 5 year period	50%
D6740	Retainer crown – porcelain/ceramic limited to once in a 5 year period	50%
D6751	Retainer crown – porcelain fused to predominantly base metal limited to once in a 5 year period	50%
D6780	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	50%
D6781	Retainer crown – ¾ cast predominantly base metal limited to once in a 5 year period	50%
D6783	Retainer crown – ¾ porcelain/ceramic limited to once in a 5 year period	50%
D6784	Retainer crown – ¾ titanium and titanium alloys	50%
D6791	Retainer crown – full cast predominantly base metal limited to once in a 5 year period	50%
D6930	Recement or re-bond fixed partial denture	50%
D6980	Fixed partial denture repair necessitated by restorative material failure	50%
D6999	Unspecified fixed prosthodontic procedure, by report	50%
Oral Maxillofacial Prosthetics		50%
D7111	Extraction, coronal remnants – primary tooth	50%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	50%
D7220	Removal of impacted tooth – soft tissue	50%

(continued)

Code	Service	Member cost share
D7230	Removal of impacted tooth – partially bony	50%
D7240	Removal of impacted tooth – completely bony	50%
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	50%
D7250	Removal of residual tooth roots (cutting procedure)	50%
D7252	Partial extraction for immediate implant placement	50%
D7259	Nerve dissection	50%
D7260	Oroantral fistula closure	50%
D7261	Primary closure of a sinus perforation	50%
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	50%
D7280	Exposure of an unerupted tooth	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%
D7284	Excisional biopsy of minor salivary glands	50%
D7285	Incisional biopsy of oral tissue – hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	50%
D7286	Incisional biopsy of oral tissue – soft limited to removal of the specimen only; up to a maximum of 3 per date of service	50%
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	50%
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	50%
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.	50%
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	50%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	50%
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) limited to once in a 5 year period per arch	50%
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	50%
D7410	Excision of benign lesion up 1.25 cm	50%
D7411	Excision of benign lesion greater than 1.25 cm	50%
D7412	Excision of benign lesion, complicated	50%
D7413	Excision of malignant lesion up to 1.25 cm	50%
D7414	Excision of malignant lesion greater than 1.25 cm	50%
D7415	Excision of malignant lesion, complicated	50%
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	50%
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	50%
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	50%
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	50%
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	50%
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	50%
D7465	Destruction of lesion(s) by physical or chemical method, by report	50%
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	50%
D7472	Removal of torus palatinus limited to once in a patient's lifetime	50%
D7473	Removal of torus mandibularis limited to once per quadrant	50%
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	50%
D7490	Radical resection of maxilla or mandible	50%
D7509	Marsupialization of odontogenic cyst	50%
D7510	Incision and drainage of abscess – intraoral soft tissue limited to once per quadrant, same date of service	50%
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	50%
D7520	Incision and drainage of abscess – extraoral soft tissue	50%
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	50%

Code	Service	Member cost share
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	50%
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	50%
D7550	Partial ostectomy /sequestrectomy for removal of non–vital bone limited to once per quadrant per date of service	50%
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%
D7610	Maxilla – open reduction (teeth immobilized, if present)	50%
D7620	Maxilla – closed reduction (teeth immobilized, if present)	50%
D7630	Mandible – open reduction (teeth immobilized, if present)	50%
D7640	Mandible – closed reduction (teeth immobilized, if present)	50%
D7650	Malar and/or zygomatic arch – open reduction	50%
D7660	Malar and/or zygomatic arch – closed reduction	50%
D7670	Alveolus – closed reduction, may include stabilization of teeth	50%
D7671	Alveolus – open reduction, may include stabilization of teeth	50%
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	50%
D7710	Maxilla – open reduction	50%
D7720	Maxilla – closed reduction	50%
D7730	Mandible – open reduction	50%
D7740	Mandible – closed reduction	50%
D7750	Malar and/or zygomatic arch – open reduction	50%
D7760	Malar and/or zygomatic arch – closed reduction	50%
D7770	Alveolus – open reduction stabilization of teeth	50%
D7771	Alveolus, closed reduction stabilization of teeth	50%
D7780	Facial bones – complicated reduction with fixation and multiple approaches	50%
D7810	Open reduction of dislocation	50%
D7820	Closed reduction of dislocation	50%
D7830	Manipulation under anesthesia	50%
D7840	Condylectomy	50%
D7850	Surgical discectomy, with/without implant	50%
D7852	Disc repair	50%
D7854	Synovectomy	50%
D7856	Myotomy	50%
D7858	Joint reconstruction	50%
D7860	Arthrotomy	50%
D7865	Arthroplasty	50%
D7870	Arthrocentesis	50%
D7871	Non–arthroscopic lysis and lavage	50%
D7872	Arthroscopy – diagnosis, with or without biopsy	50%
D7873	Arthroscopy – lavage and lysis of adhesions	50%
D7874	Arthroscopy – disc repositioning and stabilization	50%
D7875	Arthroscopy – synovectomy	50%
D7876	Arthroscopy – discectomy	50%
D7877	Arthroscopy – debridement	50%
D7880	Occlusal orthotic device, by report	50%
D7881	Occlusal orthotic device adjustment	50%
D7899	Unspecified TMD therapy, by report	50%
D7910	Suture of recent small wounds up to 5 cm	50%
D7911	Complicated suture – up to 5 cm	50%
D7912	Complicated suture – greater than 5 cm	50%
D7920	Skin graft (identify defect covered, location and type of graft)	50%
D7922	Placement of intra–socket biological dressing to aid in hemostasis or clot stabilization, per site	50%
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	50%
D7940	Osteoplasty – for orthognathic deformities	50%

(continued)

Code	Service	Member cost share
D7941	Osteotomy – mandibular rami	50%
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	50%
D7944	Osteotomy – segmented or subapical	50%
D7945	Osteotomy – body of mandible	50%
D7946	LeFort I (maxilla – total)	50%
D7947	LeFort I (maxilla – segmented)	50%
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	50%
D7949	LeFort II or LeFort III – with bone graft	50%
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report	50%
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	50%
D7952	Sinus augmentation via a vertical approach	50%
D7955	Repair of maxillofacial soft and/or hard tissue defect	50%
D7961	Buccal/labial frenectomy (frenulectomy)	50%
D7962	Lingual frenectomy (frenulectomy)	50%
D7963	Frenuloplasty limited to once per arch per date of service	50%
D7970	Excision of hyperplastic tissue – per arch limited to once per arch per date of service	50%
D7971	Excision of pericoronal gingiva	50%
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	50%
D7979	Non–surgical sialolithotomy	50%
D7980	Surgical sialolithotomy	50%
D7981	Excision of salivary gland, by report	50%
D7982	Sialodochoplasty	50%
D7983	Closure of salivary fistula	50%
D7990	Emergency tracheotomy	50%
D7991	Coronoidectomy	50%
D7995	Synthetic graft – mandible or facial bones, by report	50%
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	50%
D7999	Unspecified oral surgery procedure, by report	50%
Orthodontics		50%
	Medically necessary banded case (The copayment applies to a member's course of treatment as long as that member remains enrolled in this plan.)	50%
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	

Code	Service	Member cost share
Adjunctive General Services		
D9110	Palliative treatment of dental pain – per visit	50%
D9120	Fixed partial denture sectioning	50%
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	50%
D9211	Regional block anesthesia	50%
D9212	Trigeminal division block anesthesia	50%
D9215	Local anesthesia in conjunction with operative or surgical procedures	50%
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	50%
D9222	Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof	50%
D9223	Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof	50%
D9224	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	50%
D9225	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	50%
D9230	Administration of nitrous oxide	50%
D9239	Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof	50%
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof	50%
D9244	In-office administration of minimal sedation – single drug – enteral	50%
D9245	Administration of moderate sedation – enteral	50%
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	50%
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	50%
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	50%
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	50%
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	50%
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	50%
D9612	Therapeutic parenteral drug, two or more administrations, different medications	50%
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	50%
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	50%
D9950	Occlusion analysis – mounted case limited to once in a 12-month period	50%
D9951	Occlusal adjustment – limited. Limited to once in a 12-month period per quadrant	50%
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis– mounted case (D9950)	50%
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."

Pediatric dental care program exclusions and limitations

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

Important: If you opt to receive dental services that are not Covered Benefits under this Plan, a participating dental provider 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 Member services at **(866) 249 2382** or your broker. To fully understand your coverage, you may wish to carefully review the Health Net Individual & Family *Plan Contract and Evidence of Coverages (EOC)*.

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

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. 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.
3. Temporomandibular joint treatment (aka "TMJ").
4. Elective dentistry and cosmetic dentistry.
5. 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).
6. Treatment of malignancies, cysts, neoplasms, or congenital malformations.
7. Prescription medications.
8. Hospital charges of any kind.
9. Loss or theft of full or partial dentures.
10. Any procedure of implantation.
11. Any experimental procedure. Experimental 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. See the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" in the Health Net Individual & Family *Plan Contract and EOC*.
12. Services that cannot be performed because of the physical or behavioral limitations of the patient.
13. 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.
14. Any procedure performed for the purpose of correcting contour, contact or occlusion.
15. Any procedure that is not specifically listed as a Covered Benefit in the Health Net Individual & Family *Plan Contract and EOC*.
16. Services that were provided without cost to the Member by state government or an agency thereof, or any municipality, county, or other subdivisions.
17. 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.
18. Dispensing of drugs not normally supplied in a dental office.
19. The cost of precious metals used in any form of dental benefits.
20. 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.
21. Dental services that are received in an Emergency Services and Care setting for conditions that are not emergencies if the Member reasonably should have known that an Emergency Services and Care situation did not exist.
22. Services from a non-network provider.



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.

Non-licensed 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:
  - Insulin,
  - 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 described in the EOC in the "Medically Necessary Dental Services" provision of the "Covered Services and Supplies" section or as provided as a supplemental benefit or 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 dental provider 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 dental provider, except as specifically described under the "Pediatric Dental Services" "Pediatric and Plus Plan 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:

1. 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,
2. Craniofacial anomaly. Written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,
3. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
4. A crossbite of individual anterior teeth causing destruction of soft tissue,
5. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
6. 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.

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

Principal benefits and coverages for dental care with Ambetter PPO Plus Plans

Refer to the "Benefits for Plus Plan Dental Services" portion of the "Covered Services and Supplies" section of the *Plan Contract and EOC* for complete benefit information.

You can see any licensed dentist and receive benefits for Covered Benefits. However, if you do see a Participating Provider, charges for Covered Benefits will be limited to Health Net's contracted amount with the provider. Refer to the "Plus Plan Dental Services (ages 19 and older)" portion of "Exclusions and Limitations" in the *Plan Contract and EOC* for limitations on covered dental services.

Dental Plan Schedule of Benefits

Benefit description		In-network/Out-of-network Member Pays
Deductible (Individual/Family)	$50/$150	
Annual Maximum	$1,000	
Diagnostic and Preventive Services Periodic Oral Evaluation	50%	50%
Radiographs	50%	50%
Lab and Other Diagnostic Tests	50%	50%
Dental Prophylaxis (Cleaning)	50%	50%
Fluoride Treatment	50%	50%
Sealants – per tooth	50%	50%
Space Maintainers	50%	50%
Basic Services Restorations (Amalgams or Resin-based composite)	50%	75%
Emergency Treatment of Dental Pain	50%	75%
Simple Extractions	50%	75%
Major Services Oral Surgery	50%	75%
Periodontics	50%	75%
Endodontics	50%	75%
Inlays/Onlays/Crowns	50%	75%
Dentures and Removable Prosthetics	50%	75%
Fixed Partial Dentures (Bridges)	50%	75%

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

IMPORTANT: If you opt to receive dental services that are not Covered Benefits under this plan, a participating dental provider 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 this Evidence of Coverage document.

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 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 Ambetter PPO 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.

Principal exclusions and limitations for dental care with Ambetter PPO Plus Plans

Health Net will not pay expenses incurred for any of the following:

1. Dental services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
4. Reconstructive surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental Services, Investigational Services or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental Services, Investigational Services or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental Services, Investigational Services or unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Member becoming enrolled under the *Plan Contract and EOC*.
10. Dental services otherwise covered under the *Plan Contract and EOC* but rendered after the date individual coverage under the *Plan Contract and EOC* terminates, including dental services for dental conditions arising prior to the date individual coverage under the *Plan Contract and EOC* terminates.
11. Services rendered by a provider with the same legal residence as a Member or who is a Member of a Member's family, including spouse, brother, sister, parent or child.
12. Foreign services are not Covered unless required as an emergency.
13. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).
17. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
18. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
19. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
20. Services related to the Temporomandibular Joint (TMJ), either bilateral or unilateral. Upper and lower jaw-bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
21. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
22. Drugs/medication, obtainable with or without prescription, unless they are dispensed and utilized in the dental office during the patient visit.
23. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
25. Local anesthesia is not covered in conjunction with operative or surgical procedures.
26. Consultation is not covered if done with exams or professional visits.
27. In the event that a non-network dentist routinely waives Copayments and/or the Deductible for a particular dental service, the dental service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the non-network provider.
28. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Vision coverage included with Ambetter PPO Plus Plans (for ages 19 and over)

Principal benefits and coverages for vision provided with Ambetter PPO 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 Ambetter PPO 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, log on to **www.myhealthnetca.com** and click on Find a Doctor. If you need help in selecting a provider, call the Health Net Vision Member Services Department at 1-866-392-6058.

Copayments for vision service benefits under the Ambetter PPO 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 Ambetter PPO Plus plans

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT AND 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 Calendar Year)	$0, plus 20% off the balance over the $80 allowance
Single vision	$40
Bifocal	$40
Trifocal	$40
Lenticular	$40
Standard Progressive Lenses	$105
Premium Progressive Lenses Lens Options (In Addition to Standard Lenses)	$105, plus 20% off the balance over the $120 allowance
Lens Options (In Addition to Standard Lenses)	50%
Endodontics	50%
Inlays/Onlays/Crowns	50%
Dentures and Removable Prosthetics	50%
Fixed Partial Dentures (Bridges)	50%
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 Contact Lenses (every Calendar Year) (in lieu of eyeglass lenses; includes material only):	 20% off retail price
Medically Necessary Contact Lenses*	$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 Calendar Year.

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.

*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 Calendar Year 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 and all applicable exclusions and limitations.

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 Ambetter PPO Plus plans

The following vision services and expenses are not covered under the Ambetter PPO 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, Prior Authorization by Health Net, and all applicable exclusions and limitations. 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

This section defines words that will help you understand your Plan. These words appear throughout this Plan Contract and EOC with the initial letter of the word in capital letters.

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.

Average Wholesale Price ("AWP") for any Prescription Drug is the amount listed in a national pharmaceutical pricing publication and accepted as the standard price for that drug by Health Net.

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. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for 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 still under patent, 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 continuous twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Calendar Year Deductible is the amount of medical and Outpatient Prescription Drug Covered Expenses which must be incurred by you or your family each Calendar Year and for which you or your family have payment responsibility before benefits become payable by Health Net.

Coinsurance is the percentage of the Covered Expenses, for which the Member is responsible, as specified in the "Schedule of Benefits" section.

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.

Contracted Rate is the rate that Preferred Providers are allowed to charge you, based on a contract between Health Net and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fee charged to you for Covered Benefits when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each Covered Benefit is shown in the "Schedule of Benefits" 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.

Covered Expenses are expenses incurred by the Member for covered medical services and treatment (including Covered Benefits related to Mental Health or Substance Use Disorders) while covered under this Plan. It is not necessarily the amount a Physician or provider bills for a service. The amount of Covered Expenses varies by whether the Member obtains services from a Preferred Provider or an Out-of-Network Provider. Any expense incurred which exceeds the following amounts is not a Covered Expense: (i) for the cost of services or supplies from a Preferred Provider, the Contracted Rate; (ii) for the cost of services or supplies from an Out-of-Network Provider, the Maximum Allowable Amount. For more details about the Maximum Allowable Amount, refer to the "Maximum Allowable amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and EOC*.

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 for which the 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.

Deductible is a set amount you pay for specified Covered Expenses before Health Net pays any benefits for those Covered Expenses in that Calendar Year. Refer to the "Schedule of Benefits" 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 EOC, the Subscriber's partner if the Subscriber and partner are a couple who are Domestic Partners that meet all the requirements of Sections 297 or 299.2 of the California Family Code.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or Coinsurance or your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum).

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need 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 means 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, 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.

With regard to Acupuncture Services, "Experimental" services are acupuncture care that is a currently unproven Acupuncture Service that does not meet professionally recognized, valid, evidence-based standards of practice.

Please refer to the "Independent Medical Review of Investigational or Experimental Therapies" provision of the "General Provisions" section as well as the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for additional information.

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 Services and Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Services and 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 California licensed health care service Plan.

Health Net Ambetter PPO is the Preferred Provider Organization (PPO) Plan described in this Plan Contract and EOC, which allows you to obtain Covered Benefits and supplies from either a network of Preferred Providers or Out-of-Network Providers.

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.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in your home.

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 and 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.

Maternal Mental Health means a Mental Health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Benefits and supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network

Provider or the amount determined as set forth in the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and EOC*. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Benefit; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles, and other applicable amounts set forth in this *Plan Contract and EOC*.

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net. To get an estimate of charges for Prescription Drugs that are subject to a Deductible, visit the Health Net website at **www.myhealthnetca.com** or call Health Net's Customer Contact Center at the number shown on your Health Net ID card.

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.

Medicare Allowable Amount Health Net uses available guidelines of Medicare to assist in its determination as to which services and procedures are eligible for reimbursement. Health Net will, to the extent applicable, apply Medicare claim processing rules to claims submitted. Health Net will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the Maximum Allowable Amount, as defined above, if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

The Medicare Allowable Amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

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.

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-Network Providers are Physicians, Hospitals, laboratories, or other providers of health care licensed to and providing services in California who are not part of the Health Net Preferred Provider Organization (PPO), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which you or your family must pay for medical, Outpatient Prescription Drug, pediatric dental and pediatric vision Covered Expenses during a Calendar Year. After that maximum is reached for services provided by a Preferred Provider, and out-of-network Emergency Services and Care (including emergency Hospital care and emergency transportation), your payment responsibilities for Copayments and Coinsurance will no longer apply for Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits." Penalties paid for services which were not authorized as required will not be applied to the Out-of-Pocket Maximum, and your responsibility for these penalties will continue to apply to these expenses after the Out-of-Pocket Maximum is reached. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum. Deductibles, Copayments and Coinsurance for out-of-network Emergency Services and Care, including emergency Hospital care and emergency medical transportation, accrues to the in-network Out-of-Pocket Maximum.

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. Services provided at a facility under the out-of-network level of benefit must meet these same licensing requirements.

Participating Mental Health Professional is a Physician or other professional who is licensed 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 rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section. Services provided by a mental health professional under the out-of-network benefit level must meet these same licensing requirements.

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

Participating Providers (See "Preferred Providers" definition).

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. Care from the following providers is also covered, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this *Plan Contract and EOC* and when benefits would be payable if the services were provided by a Physician as defined above:

- Dentist (D.D.S.)
- Optometrist (O.D.)
- Dispensing optician
- Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- Psychologist
- Acupuncturist (A.C.)
- Nurse midwife
- Nurse Practitioner
- Physician Assistant
- Clinical social worker (M.S.W. or L.C.S.W.)
- Marriage, family and child counselor (M.F.C.C.)
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist
- Audiologist
- Occupational therapist (O.T.R.)
- Psychiatric mental health nurse
- Respiratory care practitioner
- Other Mental Health or Substance Use Disorder providers, including, but not limited, to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

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.

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

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.

Preferred Providers are Physicians, Hospitals, laboratories, or other providers of health care who have a written agreement with Health Net to participate in the Health Net Preferred Provider Organization (PPO) and have contracted to provide the Members of Health Net with health care at a Contracted Rate (the Contracted Rate), except as specified under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center." The Contracted Rate will be the contracted amount that will serve as payment in full for the Member. Preferred Providers are listed in the Health Net Ambetter PPO Network Directory.

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 Allowable Charge is the lesser of pharmacy's cost of the prescription or is the charge that Participating Pharmacies and the mail service program have agreed to charge Members, based on a contract between Health Net and such provider.

Prescription Drug Covered Expenses are the maximum charges Health Net will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order; it is not necessarily the amount the pharmacy will bill. Any expense incurred which exceed the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; and (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

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) directly related to the treatment of an illness or injury and which is issued by a Physician within the scope of their professional license.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in the "Schedule of Benefits" and "Covered Services and Supplies" sections. 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; and
- monitor the physical and mental development in children.

Primary Care Physician is a Physician who maintains an ongoing relationship with you and who knows you well and whom you trust in as an important part of a good health care program. Primary Care Physicians include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists. Information on how to select a Primary Care Physician and a listing of the Primary Care Physician's in the Service Area, are available on the Health net website at www.myhealthnetca.com. You can also call the Customer Contact Center at the number shown on your Health Net ID card to request provider information.

Prior Authorization refers to the requirement that certain Covered Expenses require review and approval, frequently prior to the expenses being incurred. The "Schedule of Benefits" shows the penalties applicable to those expenses which are authorized in accordance with the provisions of the EOC, and those expenses which are not so authorized. The requirements for Prior Authorization are described in the "Prior Authorization Requirement" section of this Plan Contract and EOC.

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:

- Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;
- Is supervised by a Qualified Autism Service Provider;
- Provides treatment pursuant to a treatment Plan developed and approved by the Qualified Autism Service Provider; and Is either of the following:
  - 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
  - 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;
- Is either of the following:
  - 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
  - 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; and
- 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 "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 Physician who delivers specialized services and supplies to the Member.

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 that consist of nonpreferred Brand Name Drugs or 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. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

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 Services and 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។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ 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 shichį' yídooltah nínízingo t'áá ná ákódoolníłł. 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 Вас при 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): звоните по 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 c`âu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, nếu 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

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Contact Us

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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

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