Individual & Family CommunityCare HMO and PureCare HSP Plans

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

Health Net®

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 it, 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.

The benefits described under this Disclosure Form do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, domestic partner status, or religion, and are not subject to any pre-existing condition or exclusion period.

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

Please read this important notice about the Health Net HMO CommunityCare Network health plan service area and obtaining services from CommunityCare Network physicians and hospital providers

Except for emergency care, benefits for physician and hospital services under this Health Net HMO CommunityCare Network (CommunityCare Network) plan are only available when you live in the CommunityCare Network service area and use a CommunityCare Network physician or hospital. When you enroll in this CommunityCare Network plan, you may only use a physician or hospital that is in the CommunityCare Network, and you must choose a CommunityCare Network primary care physician (PCP). You may obtain ancillary, pharmacy or behavioral health covered services and supplies from any Health Net participating ancillary, pharmacy or behavioral health provider.

Obtaining covered services under the Health Net HMO CommunityCare Network plan

Type of provider	Hospital	Physician	Ancillary	Pharmacy	Behavioral health
Available from	[1]Only CommunityCare Network hospitals	[1]Only CommunityCare Network physicians	All Health Net contracting ancillary providers	Advanced Choice Pharmacy Network	All Health Net contracting behavioral health providers

[1]The benefits of this plan for physician and hospital services are only available for covered services received from a CommunityCare Network physician or hospital, except for (1) urgently needed care outside a 30-mile radius of your physician group and all emergency care; (2) referrals to non-CommunityCare Network providers are covered when the referral is issued by your CommunityCare Network physician group; and (3) covered services provided by a non-CommunityCare Network provider when authorized by Health Net.

The CommunityCare Network service area and a list of its physicians and hospital providers are shown in the *Health Net CommunityCare Network Provider Directory,* which is available online at **www.myhealthnetca.com**. You can also contact Health Net's Customer Contact Center at **1-877-609-8711** to request provider information. The *Health Net CommunityCare Network Provider Directory* is different from other Health Net provider directories.

Note: Not all physicians and hospitals who contract with Health Net are CommunityCare Network providers. Only those physicians and hospitals specifically identified as participating in the CommunityCare Network may provide services under this plan, except as described in the chart above.

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

- Health Net
- Health Net service area
- Hospital
- Member physician, participating physician group, primary care physician, physician, participating provider, contracting physician groups, and contracting providers
- Network
- Provider Directory

If you have any questions about the CommunityCare Network service area, choosing your Community Care Network PCP, how to access specialist care, or your benefits, please contact the Health Net Customer Contact Center at **1-877-609-8711**.

Please read this important notice about the Health Net PureCare HSP Network health plan service area and obtaining services from PureCare Network physicians and hospital providers

Except for emergency and urgently needed care, benefits for physician and hospital services under this Health Net PureCare HSP (PureCare Network) plan are only available when you live in the PureCare HSP Network service area and use a PureCare Network participating physician or hospital. When you enroll in this PureCare Network plan, you may only use a participating physician or hospital who is in the PureCare Network, and you are required to choose a PureCare primary care physician (PCP). You may obtain ancillary, pharmacy or behavioral health covered services and supplies from any Health Net participating ancillary, pharmacy or behavioral health provider.

Obtaining covered services under the Health Net PureCare HSP Network plan

Type of provider	Hospital	Physician	Ancillary	Pharmacy	Behavioral health
Available from	[1]Only PureCare Network hospitals	[1]Only PureCare Network physicians	All Health Net contracting ancillary providers	All Health Net participating pharmacies	All Health Net contracting behavioral health providers

[1]The benefits of this plan for physician and hospital services are only available for covered services received from a PureCare Network participating physician or hospital, except for emergency and urgently needed care.

The PureCare Network service area and a list of its participating physicians and hospital providers are shown in the *Health Net PureCare HSP Network Provider Directory*, which is available online at **www.myhealthnetca.com**. You can also contact the Health Net Customer Contact Center at **1-877-609-8711** to request provider information. The *Health Net PureCare HSP Network Provider Directory* is different from other Health Net provider directories.

Note: Not all physicians and hospitals who contract with Health Net are PureCare Network participating providers. Only those physicians and hospitals specifically identified as participating providers in the PureCare Network may provide services under this plan, except as described in the chart above.

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

- Health Net
- Health Net service area
- Hospital
- Primary care physician, participating physician, physician, participating provider, and contracting providers
- Network
- Provider Directory

If you have any questions about the PureCare Network service area, choosing a PCP, how to access care, or your benefits, please contact the Health Net Customer Contact Center at **1-877-609-8711**.

Health Net Individual & Family coverage for you and your family

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

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

HSP – Our Individual & Family Plan Health Care Service Plan (HSP) plans are designed for people who want to see any participating physician or health care professional without first obtaining a referral. You are required to choose a PCP from our PureCare HSP Network, but you can go directly to any participating provider in our network at any time with no need for a referral. When you choose one of our HSP plans, you may only use a participating provider who is in the Health Net PureCare Network.

Is an HMO right for you?

With our HMO plans, you are required to choose a PCP. Your PCP will provide and coordinate your medical care. You have the right to designate any PCP who participates in our Health Net CommunityCare Network, has an office close enough to your residence to allow reasonable access to medical care and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the PCP. Until you make your PCP designation, Health Net designates one for you. Information about how to select a PCP and a listing of the participating PCPs in the Health Net CommunityCare service area are available on the Health Net website at **www.myhealthnetca.com**. You can also call **1-877-609-8711** to request provider information, or contact your Health Net authorized broker.

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

Your PCP must first be contacted for initial treatment and consultation before you receive any care or treatment through a hospital, specialist or other health care provider, except for OB/GYN visits, and reproductive and sexual health care services, as set out below. All treatments recommended by such providers must be authorized by your PCP.

You do not need prior authorization (HMO) or prior certification (HSP) from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical, gynecological, or reproductive and sexual health care services from an in-network health care professional who specializes in obstetrics, gynecology, or reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization (HMO) or prior certification (HSP) for certain services, following a pre-approved treatment plan, or procedures for making referrals. A listing of participating health care professionals who specialize in obstetrics, gynecology, or reproductive and sexual health is available on the Health Net website at **www.myhealthnetca.com**. You can also call **1-877-609-8711** to request provider information or contact your Health Net authorized broker. Refer to the "Mental disorders and chemical dependency services" section in this document for information about receiving care for mental disorders and chemical dependency.

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

Is an HSP right for you?

With the Health Net HSP, you may go directly to any PureCare HSP participating provider. Simply find the provider you wish to see in the *Health Net PureCare HSP Participating Provider Directory* and schedule an appointment. Participating providers accept a special rate, called the contracted rate, as payment in full. Your share of costs is based on that contracted rate. All benefits of an HSP plan (except emergency and urgently needed care) must be provided by a participating provider in order to be covered.

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 PureCare HSP, you are required to select a PCP for yourself and each member of your family. When selecting a PCP, choose a participating physician close enough to your residence to allow reasonable access to medical care. Information about how to select a PCP and a listing of the participating physicians in the Health Net PureCare HSP 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 PureCare HSP plan are subject to a requirement of certification in order for a noncertification penalty to not apply. See the "Certification requirements for HSP plans only" section on the next page.

Calendar year deductible

For some HMO and HSP 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 reach the amount for any one member or when your

entire family reaches the family amount. Family deductibles are equal to two times the individual deductible. If your plan has a calendar year deductible, that deductible does not apply to adult dental and vision services benefits under the HMO Plus plans or HSP Plus plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" in this document). In addition, if your plan has a calendar year deductible, copayments for adult dental and vision services benefits under the HMO Plus plans or HSP Plus plans do not accrue toward that deductible.

Out-of-pocket maximum

Copayments and deductibles that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum (OOPM). The family OOPM is equal to two times the individual OOPM. After you or your family members meet your OOPM, you pay no additional amounts for covered services and supplies for the balance of the calendar year. Once an individual member in a family satisfies the individual OOPM, the remaining enrolled family members must continue to pay the copayments and deductibles until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family OOPM or (b) each enrolled family member individually satisfies the individual OOPM. You are responsible for all charges related to services or supplies not covered by the health plan. Payments for services or supplies not covered by this plan will not be applied to this yearly OOPM. Copayments for adult dental and vision services benefits under the HMO Plus plans or HSP Plus plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" in this document) do not accrue toward your OOPM. For the HSP plans, penalties paid for services which were not certified as required do not apply to the yearly OOPM (see "Certification requirements for HSP plans only" on this page). For the family OOPM to apply, you and your family must be enrolled as a family.

Certification requirements for HSP plans only

For the HSP plans, certain covered services require Health Net's (medical) or the administrator's (mental disorders or chemical dependency) review and approval, called certification, before they are obtained. If these services are not certified before they are received, you will be responsible for paying a $250 noncertification penalty. These penalties do not apply to your out-of-pocket maximum.

We may revise the prior certification list from time to time. Any such changes, including additions and deletions from the prior certification list, will be communicated to participating providers and posted on the www.myhealthnetca.com website. Certification 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 certified, eligibility rules and benefit limitations will still apply. See the Individual & Family Plan *Plan Contract and EOC* for details.

Services that require certification include:

Inpatient admissions[1]

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Behavioral health facility
- Hospice

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

- Hospital
- Skilled nursing facility
- Substance abuse facility

Outpatient procedures, services or equipment

1. Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
2. Acupuncture
3. Abdominal paracentesis (when performed at a hospital)
4. Ambulance: non-emergency air or ground ambulance services
5. Balloon sinuplasty
6. Bariatric procedures
7. Capsule endoscopy
8. Carpal tunnel (when performed at a hospital)
9. Cataract surgery (when performed at a hospital)
10. Cleft palate reconstruction, including dental and orthodontic services
11. Clinical trials
12. Cochlear implants
13. Custom orthotics
14. Diagnostic procedures, including:
    - Advanced imaging
      - CT (computerized tomography)
      - CTA (computed tomography angiography)
      - MRA (magnetic resonance angiography)
      - MRI (magnetic resonance imaging)
      - PET (positron emission tomography)
    - Cardiac imaging
      - Coronary computed tomography angiography (CCTA)
      - Myocardial perfusion imaging (MPI)
      - Multigated acquisition (MUGA) scan
      - Echocardiography
    - Sleep studies
15. Durable medical equipment
16. Enhanced external counterpulsation (EECP)
17. Experimental/Investigational services and new technologies
18. Gender reassignment services
19. Genetic testing
20. Hernia repair (when performed at a hospital)
21. Injections, including epidural, nerve, nerve root, facet joint, trigger point, and sacroiliac (SI) joint injections
22. Liposuction
23. Liver biopsy (when performed at a hospital)
24. Medically necessary 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.
25. Mental disorders and chemical dependency services, including:
    - Psychological testing
    - Neuropsychological testing
    - Outpatient detoxification
    - Outpatient electroconvulsive therapy (ECT)
    - Transcranial magnetic stimulation (TMS)
    - Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
    - Partial hospital program (PHP) or day hospital
    - Half-day partial hospitalization
    - Intensive outpatient program (IOP)
26. Neuro or spinal cord stimulator
27. Neuropsychological testing
28. Occupational and speech therapy (includes home setting)
29. Orthognathic procedures (includes TMJ treatment)
30. Outpatient pharmaceuticals
    - Self-injectables
    - Certain physician-administered drugs, including newly approved drugs, whether

administered in a physician office, free-standing infusion center, ambulatory surgery 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 certification.

31. Physical therapy (includes home setting)
32. Potentially cosmetic services devices or procedures such as
    a. Breast reductions and augmentations, except when following a mastectomy
       – Includes mastectomy for gynecomastia
    b. Blepharoplasty (includes brow ptosis)
    c. Canthoplasty
    d. Dermatology – in-office procedures
       – Skin injections and implants
       – Dermabrasion/Chemical peel
       – Laser treatment
       – Chemical exfoliation and electrolysis
    e. 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
    f. Liposuction
    g. Osteoplasty
    h. Otoplasty
    i. Penile implant
    j. Rhinoplasty
    k. Septoplasty
    l. Treatment of varicose veins
    m. Vermilionectomy with mucosal advancement
33. Prosthesis items
34. Radiation therapy
35. Referrals to nonparticipating providers
36. Spinal surgery, including but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization, and X-STOP
37. Testosterone therapy
38. Tonsillectomy and adenectomy (when performed at a hospital)
39. Total joint replacements (hip, knee, shoulder, and ankle)
40. Transplant-related services
41. Upper and lower gastrointestinal (GI) endoscopy (when performed at a hospital)
42. Urologic procedures (when performed at a hospital)
43. Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP
44. Vestibuloplasty

Timely access to care

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

You may contact Health Net at the number shown on the back cover, 7 days a week, 24 hours a day, to access triage or screening services. Health Net provides access to covered health care services in a timely manner.

For further information, please refer to the Individual & Family Plan HMO or HSP *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)[2]

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 HMO Plus plans and Health Net HSP Plus plans. A Health Net "Plus" plan is a Health Net HMO or HSP 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.

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

Plan Overview – Platinum 90 CommunityCare HMO

The Platinum 90 HMO health plan utilizes the **CommunityCare HMO** provider network for covered benefits and services.

CommunityCare HMO is available directly through Health Net in Los Angeles, Orange, and San Diego counties, and parts of Kern, Riverside, and San Bernardino counties.

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$3,350 single / $6,700 family
Professional services Office visit copay[1]	$15
Specialist visit[1]	$30
Other practitioner office visit (including medically necessary acupuncture)[2]	$15
Preventive care services[1,3]	$0
X-ray and diagnostic imaging	$30
Laboratory tests	$15
Imaging (CT, PET scans, MRIs)	$75
Rehabilitation and habilitation therapy	$15
Outpatient services Outpatient surgery	$100 facility / $25 physician
Hospital services Inpatient hospital facility (includes maternity)	Facility: $250/day (up to 5 days); physician: $0
Skilled nursing care	$150/day up to 5 days[4]
Emergency services Emergency room services (copays waived if admitted)	$150 facility / $0 physician
Urgent care	$15
Ambulance services (ground and air)	$150
Mental/Behavioral health / Substance use disorder services[5] Mental/Behavioral health / Substance use disorder (inpatient)	Facility: $250/day (up to 5 days); physician: $0
Mental/Behavioral health / Substance use disorder (outpatient)	$15 office visit / $0 other than office visit
Home health care services (100 visits per calendar year)	$20
Other services Durable medical equipment	10%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$5
Tier 2 (non-preferred generics and preferred brand)	$15
Tier 3 (non-preferred brand)	$25
Tier 4 (Specialty drugs)[10]	10% up to $250/script
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

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

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

[3]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 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.

[4]No additional copayment after the first 5 days of a continuous skilled nursing facility stay.

[5]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[6]Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

[7]If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[8]Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. If a brand-name preventive drug or women's contraceptive is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name preventive drug or women's 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 are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[9]The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the list may require prior authorization from Health Net. Drugs that are not listed on the list (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers 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 his or her designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 (Specialty Drugs) copayment, when determined to be medically necessary.

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

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

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

Plan Overview – Gold 80 CommunityCare HMO

The Gold 80 HMO health plan utilizes the **CommunityCare HMO** provider network for covered benefits and services.

CommunityCare HMO is available directly through Health Net in Los Angeles, Orange, and San Diego counties, and parts of Kern, Riverside, and San Bernardino counties.

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$7,200 single / $14,400 family
Professional services Office visit copay[1]	$30
Specialist visit[1]	$55
Other practitioner office visit (including medically necessary acupuncture)[2]	$30
Preventive care services[1,3]	$0
X-ray and diagnostic imaging	$55
Laboratory tests	$35
Imaging (CT, PET scans, MRIs)	$275
Rehabilitation and habilitation therapy	$30
Outpatient services Outpatient surgery	$300 facility / $40 physician
Hospital services Inpatient hospital facility (includes maternity)	Facility: $600/day up to 5 days; physician: $0
Skilled nursing care	$300/day up to 5 days[4]
Emergency services Emergency room services (copays waived if admitted)	$325 facility / $0 physician
Urgent care	$30
Ambulance services (ground and air)	$250
Mental/Behavioral health / Substance use disorder services[5] Mental/Behavioral health / Substance use disorder (inpatient)	Facility: $600/day up to 5 days; physician: $0
Mental/Behavioral health / Substance use disorder (outpatient)	Office visit: $30 / Other than office visit: $0
Home health care services (100 visits per calendar year)	$30
Other services Durable medical equipment	20%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$15
Tier 2 (non-preferred generics and preferred brand)	$55
Tier 3 (non-preferred brand)	$75
Tier 4 (Specialty drugs)[10]	20% up to $250/script
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

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

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

[3]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 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.

[4]No additional copayment after the first 5 days of a continuous skilled nursing facility stay.

[5]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[6]Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

[7]If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[8]Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. If a brand-name preventive drug or women's contraceptive is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name preventive drug or women's 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 are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[9]The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the list may require prior authorization from Health Net. Drugs that are not listed on the list (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers 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 his or her designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 (Specialty Drugs) copayment, when determined to be medically necessary.

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

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

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

Plan Overview – Silver 70 Off Exchange CommunityCare HMO

The Silver 70 Off Exchange HMO health plan utilizes the **CommunityCare HMO** provider network for covered benefits and services.

CommunityCare HMO is available directly through Health Net in Los Angeles, Orange, and San Diego counties, and parts of Kern, Riverside, and San Bernardino counties.

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility[1]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible[1]	$2,500 single / $5,000 family
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$7,550 single / $15,100 family
Professional services Office visit copay[2]	$40 (deductible waived)
Specialist visit[2]	$80 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture)[3]	$40 (deductible waived)
Preventive care services[2,4]	$0 (deductible waived)
X-ray and diagnostic imaging	$75 (deductible waived)
Laboratory tests	$35 (deductible waived)
Imaging (CT, PET scans, MRIs)	$300 (deductible waived)
Rehabilitation and habilitation therapy	$40 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	20% (deductible waived)
Hospital services Inpatient hospital facility (includes maternity)	Facility: 20%; physician: 20% (deductible waived)[5]
Skilled nursing care	20%
Emergency services Emergency room services (copay waived if admitted)	$350 facility (deductible waived) / $0 physician (deductible waived)
Urgent care	$40 (deductible waived)
Ambulance services (ground and air)	$255
Mental/Behavioral health / Substance use disorder services[6] Mental/Behavioral health / Substance use disorder (inpatient)	Facility: 20%; physician: 20% (deductible waived)[5]
Mental/Behavioral health / Substance use disorder (outpatient)	Office visit: $40 (deductible waived) Other than office visit: $0 (deductible waived)
Home health care services (100 visits per calendar year)	$45 (deductible waived)
Other services Durable medical equipment	20% (deductible waived)
Hospice service	$0 (deductible waived)
Prescription drug coverage[7,8,9,10,11] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	$200 single / $400 family
Tier 1 (most generics and low-cost preferred brand)	$15 (Rx deductible applies)
Tier 2 (non-preferred generics and preferred brand)	$55 (Rx deductible applies)
Tier 3 (non-preferred brand)[10]	$80 (Rx deductible applies)
Tier 4 Specialty drugs[12]	20% up to $250/script after Rx deductible

Benefit description	Member(s) responsibility[1]
Pediatric dental[13] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[14] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0 (deductible waived)

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

[1]For certain services and supplies under this plan, a calendar year deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed the deductible. The calendar year deductible applies, unless specifically noted above.

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

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

[4]Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents, and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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

[6]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[7]Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

[8]If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[9]The prescription drug deductible (per calendar year) must be paid before Health Net begins to pay. If you are a member in a family of two or more members, you reach the prescription drug deductible either when you meet the amount for any one member or when your entire family reaches the family amount. The prescription drug deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a participating pharmacy, and preventive drugs and women's contraceptives. Prescription drug-covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

[10]Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. If a brand-name preventive drug or women's contraceptive is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name preventive drug or women's 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 are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[11]The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the list may require prior authorization from Health Net. Drugs that are not listed on the list (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers 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 his or her designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 (Specialty Drugs) copayment, when determined to be medically necessary.

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

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

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

Plan Overview – Bronze 60 PureCare HSP

The Bronze 60 HSP health plan utilizes the **PureCare HSP** provider network for covered benefits and services.

PureCare HSP is available directly through Health Net in Kern, Los Angeles, Orange, and San Diego counties, and parts of Riverside and San Bernardino counties.

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility[1]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible[2]	 $6,300 single / $12,600 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$7,550 single / $15,100 family
Professional services Office visit copay[3]	 Visits 1–3: $75 (deductible waived)[4] / Visits 4+: $75 (deductible applies)
Specialist visit[3]	Visits 1–3: $105 (deductible waived)[4] / Visits 4+: $105 (deductible applies)
Other practitioner office visit (including medically necessary acupuncture)[5]	Visits 1–3: $75 (deductible waived)[4] / Visits 4+: $75 (deductible applies)
Preventive care services[3,6]	$0 (deductible waived)
X-ray and diagnostic imaging	100%
Laboratory tests	$40 (deductible waived)
Imaging (CT, PET scans, MRIs)	100%
Rehabilitation and habilitation services	$75 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	 100%
Hospital services Inpatient hospital stay (includes maternity)	 100%
Skilled nursing care	100%
Emergency services Emergency room services (copays waived if admitted)	 100% facility / $0 physician (deductible waived)
Urgent care	Visits 1–3: $75 (deductible waived)[4] / Visits 4+: $75 (deductible applies)
Ambulance services (ground and air)	100%
Mental/Behavioral health / Substance use disorder services[7] Mental/Behavioral health / Substance use disorder (inpatient)	 100%
Mental/Behavioral health / Substance use disorder (outpatient)	Office visit: $75 (deductible waived) / Other than office visit: 100% up to $75
Home health care services (100 visits per calendar year)	100%
Other services Durable medical equipment	 100%
Hospice service	$0 (deductible waived)
Prescription drug coverage[8,9,10,11] Prescription drugs (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	 $500 single / $1,000 family
Tier 1 (most generics and low-cost preferred brand)	100% up to $500/script (after Rx deductible)

Benefit description	Member(s) responsibility[1]
Tier 2 (non-preferred generics and preferred brand)	100% up to $500/script (after Rx deductible)
Tier 3 (non-preferred brand)	100% up to $500/script (after Rx deductible)
Tier 4 Specialty drugs[12]	100% up to $500/script (after Rx deductible)
Pediatric dental[13] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[14] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0 (deductible waived)

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 certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the *Plan Contract and EOC* for details.

[2]For certain services and supplies under this plan, including prescription drugs, a calendar year deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed the deductible. The calendar year deductible applies, unless specifically noted above.

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

[4]The calendar year deductible applies after the first 3 non-preventive visits. Non-preventive visits include urgent care visits and office visits to a specialist, physician, physician assistant, nurse practitioner, other practitioner, or postnatal office visits.

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

[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 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]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[8]Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

[9]If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[10]Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. If a brand-name preventive drug or women's contraceptive is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name preventive drug or women's 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 are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[11]The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the list may require prior authorization from Health Net. Drugs that are not listed on the list (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers 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 his or her designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 (Specialty Drugs) copayment, when determined to be medically necessary.

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

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

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

Plan Overview – Minimum Coverage PureCare HSP

The Minimum Coverage HSP health plan utilizes the **PureCare HSP** provider network for covered benefits and services.

PureCare HSP is available directly through Health Net in Kern, Los Angeles, Orange, and San Diego counties, and parts of Riverside and San Bernardino counties.

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility[1]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximum Calendar year deductible (also applies to prescription drugs)[2]	$7,900 single / $15,800 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$7,900 single / $15,800 family
Professional services Office visit copay[3]	Visits 1–3: 0% (deductible waived)[4] / Visits 4+: 0% (deductible applies)
Specialist visit[3]	0%
Other practitioner office visit (including medically necessary acupuncture)[5]	Visits 1–3: 0% (deductible waived)[4] / Visits 4+: 0% (deductible applies)
Preventive care services[3,6]	$0 (deductible waived)
X-ray and diagnostic imaging	0%
Laboratory tests	0%
Imaging (CT, PET scans, MRIs)	0%
Rehabilitation and habilitation services	0%
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	0%
Hospital services Inpatient hospital stay (includes maternity)	0%
Skilled nursing care	0%
Emergency services Emergency room services (copays waived if admitted)	0% facility / $0 physician (deductible waived)
Urgent care	Visits 1–3: 0% (deductible waived)[4] / Visits 4+: 0% (deductible applies)
Ambulance services (ground and air)	0%
Mental/Behavioral health / Substance use disorder services[7] Mental/Behavioral health / Substance use disorder (inpatient)	0%
Mental/Behavioral health / Substance use disorder (outpatient)	Office visits 1–3: 0% (deductible waived)[4] / Office visits 4+: 0% (deductible applies) Other than office visit: 0%
Home health care services (100 visits per calendar year)	0%
Other services Durable medical equipment	0%
Hospice service	0%
Self-injectables (other than insulin)[8]	0%
Prescription drug coverage[9,10,11,12] Prescription drugs (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	Integrated with medical deductible
Tier 1 (most generics and low-cost preferred brand)	0%
Tier 2 (non-preferred generics and preferred brand)	0%

Benefit description	Member(s) responsibility[1]
Tier 3 (non-preferred brand)	0%
Tier 4 (Specialty drugs)[13]	0%
Pediatric dental[14] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[15] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0

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

[1]Certain services require prior certification from Health Net. Without prior certification, an additional $250 is applied. Refer to the *Plan Contract and EOC* for details.

[2]For certain services and supplies under this plan, including prescription drugs and pediatric dental services, a calendar year deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed the deductible. The calendar year deductible applies, unless specifically noted above.

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

[4]The calendar year deductible applies after the first 3 non-preventive visits. Non-preventive visits include urgent care, office visits to a physician, physician assistant, nurse practitioner, other practitioner, or postnatal office visits.

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

[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 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]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which provides behavioral health services.

[8]Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

[9]Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

[10]If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[11]Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. If a brand-name preventive drug or women's contraceptive is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name preventive drug or women's 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 are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[12]The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the list may require prior authorization from Health Net. Drugs that are not listed on the list (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers 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 his or her designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs, including Specialty Drugs, that have a generic equivalent at the applicable Tier 2, Tier 3 or Tier 4 (Specialty Drugs) copayment, when determined to be medically necessary.

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

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

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

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 (PCP). Finding a PCP is easy with Health Net's doctor search. To find the most up-to-date list, visit www.myhealthnetca.com. You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by 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
  PO Box 1150
  Rancho Cordova, CA 95741-1150

Important things to know about your medical coverage

Who is eligible?

To be eligible for a Health Net Individual & Family plan, you must (a) live in the Health Net CommunityCare HMO service area for an HMO plan or the PureCare HSP service area for an HSP plan and (b) apply for enrollment during an open enrollment period or during a special enrollment period as defined below. In addition, your spouse or domestic partner (see next page for definition), if under age 65, and your children to age 26 are eligible to enroll as dependents. 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 ages 65 and older and eligible for Medicare benefits; (c) persons who are incarcerated; and (d) persons eligible for Medi-Cal or other applicable state or federal programs.

For 2019, enrollment takes place October 15, 2018, to January 15, 2019, inclusive.

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:

- 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 or loss due to non-payment of premiums;
- 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);
- Gained or became a dependent;
- 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 contract's 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 Covered California;
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions;
- Are a victim of domestic or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2t, including a dependent or unmarried victim within a household, and 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; or
- Apply for coverage between October 15 and October 31, with an effective date of coverage of January 1, or between December 16 and January 15, with an effective date no later than February 1.

Domestic partner

A domestic partner is the subscriber's partner if the subscriber and partner are a couple who are registered domestic partners who 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, changes in benefits or plan contract provisions after the enrollment effective date, you will be notified at least 60 days in advance.

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

Can benefits be terminated?

You may cancel your coverage at any time by giving written notice to Health Net. In such event, termination will be effective on the first day of the month following Health Net's receipt of your written notice to cancel. 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 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 the "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 days' 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 the plan contract is canceled, 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; and
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 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 Health Net's Customer Contact Center at **1-800-839-2172**.

Does Health Net cover the cost of participation in 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 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 were 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 were 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 Health Net, you should first telephone Health Net at **1-877-609-8711** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet website, **http://www.hmohelp.ca.gov,** has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?

With the HSP plan, Health Net members can go directly to any PureCare HSP participating provider without a referral.

With the HMO plan, Health Net members have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Customer Contact Center at **1-877-609-8711**.

What are Health Net's premium ratios?

Health Net of California's 2017 ratio of premium costs to health services paid for Individual & Family HMO and HSP plans was 87.6 percent.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals, participating providers, and other health care providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or employees of any physician group, contract physician,

hospital, or other health care provider. All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net, its 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 services and supplies of your plan.

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

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

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

- An acute condition;
- A serious chronic condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A terminal illness (for the duration of the terminal illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information about how to request continued care, or to request a copy of the Continuity of Care Assistance Request Form or 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.

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);
- 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 such a provider, 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 non-participating 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.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information about how to request continued care, or to request a copy of the Continuity of Care Assistance Request Form or our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

What are severe mental illness and serious emotional disturbances of a child?

Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified to include atypical autism, in accordance with professionally recognized standards, including but not limited to the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date), autism, anorexia nervosa, and bulimia nervosa.

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date, other than a primary substance abuse disorder or a developmental disorder, that

result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home, or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *Plan Contract and Evidence of Coverage* and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at 1-877-609-8711 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

For its HMO plans, Health Net uses financial incentives and various risk-sharing arrangements when paying providers. For its HSP plans, Health Net pays participating physicians and other professional 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?

We will coordinate the payment for covered services when you receive care from your PCP, or for HMO plans, when you are referred by your PCP to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Health Net member ID card.

Am I required to see my primary care physician or a participating provider if I have an emergency?

Health Net covers emergency and urgently needed care throughout the world.

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

If your situation is not so severe: HMO plan members should call their primary care physician or physician group (medical) or the administrator (mental illness or detoxification). HSP plan members should call a participating provider (medical) or the administrator (mental disorders and chemical dependency).

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

Emergency care includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her 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. An 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 her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her 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 call will be covered if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

For HMO plans, all follow-up care (including severe mental illness and serious emotional disturbances of a child) after the emergency or urgency has passed and your condition is stable must be provided or authorized by your primary care physician or physician group (medical) or the administrator (mental illness and chemical dependency); otherwise, it will not be covered by Health Net.

For HSP plans, follow-up care (including severe mental illness and serious emotional disturbances of a child) after the emergency or urgency has passed and your condition is stable must be authorized by Health Net (medical) or the administrator (mental disorders and chemical dependency), or it will not be covered.

Am I liable for payment of certain services?

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

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

Some nonparticipating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment, and the emergency room or urgent care center report to us for reimbursement within one year of the date the service was rendered. For HMO plans, coverage for services rendered by nonparticipating providers is limited to emergency care and, when you are outside a 30-mile radius of your physician group, urgent care. For HSP plans, coverage for services rendered by nonparticipating or out-of-network providers is limited to emergency and urgently needed care.

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

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

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all subscribers and members under the plan for the purpose of review, investigation or evaluation of an application, claim, appeal (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.

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 or experimental 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 or experimental 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 a review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is experimental or investigational, you may request an Independent Medical Review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the *Plan Contract and Evidence of Coverage* for additional details.

What are Health Net's utilization management processes?

Utilization management is an important component of health care management. Through the processes of preauthorization, 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.

Preauthorization

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 preauthorization was required but not obtained.

Care or case management

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

Additional product information

Mental disorders and chemical dependency services

The mental disorders and chemical dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the administrator), which contracts with Health Net to administer these benefits. When you need to see a participating mental health professional, contact the administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net ID card. The administrator will help you identify a participating mental health professional, a participating independent physician or a subcontracted provider association (Independent Physicians Association (IPA)) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization (HMO) or prior certification (HSP) by the administrator in order to be covered.

Please refer to the Health Net Individual & Family plan *Plan Contract and Evidence of Coverage* for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization (HMO) or prior certification (HSP) by the administrator.

Prescription drug program

Health Net is contracted with many major pharmacies, including supermarket-based pharmacies and privately owned pharmacies in California. Please visit our website at **www.myhealthnetca.com** to find a conveniently located participating pharmacy, or call Health Net's Customer Contact Center at **1-877-609-8711**.

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

Maintenance prescriptions by mail order drug program

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

Maintenance drugs are prescription drugs taken continuously to manage chronic or long-term conditions where members respond positively to drug treatment. The mail order administrator may only dispense up to a 90-consecutive-calendar-day supply of a covered maintenance drug and each refill allowed by that order. Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit. You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at **1-877-609-8711**.

Note

Schedule II narcotic drugs are not covered through mail order. See the Health Net Individual & Family plan *Plan Contract and Evidence of Coverage* for additional information.

The Health Net "Essential Rx Drug List": Tier 1 drugs (most generic drugs and low-cost preferred brand-name drugs when listed in the "Essential Rx Drug List") and Tier 2 drugs (non-preferred generic, preferred brand-name drugs, certain brand-name drugs with a generic equivalent, peak flow meters, inhaler spacers, insulin, and diabetic supplies when listed in the "Essential Rx Drug List")

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

We specifically suggest to all Health Net participating providers, contracting PCPs 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 "Essential Rx Drug List," it ensures that you are receiving a high quality prescription medication that is also of high value.

The "Essential Rx Drug List" is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. This committee's members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the "Essential Rx 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, and
- Physician recommendations.

To obtain a copy of Health Net's most current "Essential Rx Drug List," please visit our website at **www.myhealthnetca.com**, or call Health Net's Customer Contact Center at **1-877-609-8711**.

Tier 3 drugs

Tier 3 drugs are non-preferred brand-name prescription drugs, prescription drugs that are listed as Tier 3, drugs indicated as "NF," if approved, or prescription drugs not listed on the "Essential Rx Drug List," and are not excluded from coverage.

Tier 4 (Specialty drugs)

Tier 4 (Specialty drugs) are specific prescription drugs that may have limited pharmacy availability or distribution; may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously), requiring the member to have special training or clinical monitoring for self-administration; includes biologics and drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy; or have a high cost as established by Covered California. Tier 4 (Specialty drugs) are identified in the "Essential Rx Drug List" with "SP." Refer to Health Net's "Essential Rx Drug List" on our website at www.myhealthnetca.com for the Tier 4 (Specialty drugs) listing.

All Tier 4 (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 (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 (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.

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

The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

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

Prescription drug program exclusions and limitations

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

- Allergy serum is covered as a medical benefit.
- Brand-name drugs that have generic equivalents are not covered without prior authorization from Health Net.
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers, 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 morbid obesity.
- Drugs prescribed to shorten the duration of the common cold.
- Experimental drugs (those that are labeled "Caution – Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental, you will have a right to an Independent Medical Review. See the "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.
- Individual doses of medications dispensed in plastic, unit doses or foil packages, and dosage forms used for convenience, as determined by Health Net, are covered only when medically necessary or when the medication is only available in that form.

- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.
- Some drugs are subject to specific quantity limitations per copayment based on recommendations for use by the FDA or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net.
- Medical equipment and supplies (including insulin) that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force (USPSTF) A and B recommendations, including smoking cessation drugs or for female 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 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 a clinical trial. For additional guidance, see "Does Health Net cover the cost of participation in 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 for treating sexual dysfunction, are limited to a maximum of 8 doses in any 30-day period.

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

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:

- You may receive emergency acupuncture services from any acupuncturist, including a non-contracted acupuncturist; and
- 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 require pre-approval 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; and
- Emergency acupuncture services.

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 are not covered;
- 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; and
- 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 *Plan Contract and Evidence of Coverage*.

Pediatric vision care program

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

Pediatric vision services are covered until the last day of the month in which the individual turns 19 years of age.

Professional services	Copayment
Routine eye examination with dilation	$0[1]
Examination for contact lenses Standard contact lens fit and follow-up	Up to $55
Premium contact lens fit and follow-up	10% off retail
Limitation: [1]In accordance with professionally recognized standards of practice, this plan covers one complete vision examination once every calendar year. **Note:** Examination for contact lenses is in addition to the member's vision examination. There is no additional copayment for a contact lens follow-up visit after the initial fitting exam. Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one-time-use benefits. No remaining balance. Standard contact lenses include soft, spherical and daily wear contact lenses. Premium contact lenses include toric, bifocal, multifocal, cosmetic color, post-surgical, and gas permeable contact lenses.	
Materials (includes frames and lenses)	**Copayment**
Provider-selected frames (one every 12 months)	$0
Standard plastic eyeglass lenses (one pair every 12 months) • Single vision, bifocal, trifocal, lenticular • Glass or plastic	$0
Optional lenses and treatments, including: • UV treatment • Tint (fashion and gradient and glass-grey) • Standard plastic scratch coating • Standard polycarbonate • Photochromatic / transitions plastic • Standard anti-reflective coating • Polarized • Standard progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses • Select or ultra progressive lenses	$0

Materials (includes frames and lenses)	Copayment
Premium progressive lenses	$0
Provider-selected contact lenses (in lieu of eyeglass lenses) • Extended wear disposables: up to 6-month supply of monthly or 2-week supply of disposable, single vision spherical or toric contact lenses • Daily wear/disposables: up to 3-month supply of daily disposables, single vision spherical contact lenses • Conventional: one pair from selection of provider-designated contact lenses • Medically necessary[2]	$0

[2]Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

- High ametropia exceeding -10D or +10D in meridian powers
- Anisometropia of 3D in meridian powers
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

Medically necessary contact lenses

Coverage of medically necessary contact lenses is subject to medical necessity, and all applicable exclusions and limitations.

Pediatric vision care program exclusions and limitations

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

- Services and supplies provided by a provider who is not a participating vision provider are not covered.
- Charges for services and materials that Health Net determines to be non-medically necessary are excluded. One routine eye exam with dilation is covered every calendar year and is not subject to medical necessity.
- Plano (non-prescription) lenses are excluded.
- Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization (HMO) or prior certification (HSP) 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 benefit. They are in lieu of all eyeglasses lenses and frames.
- Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of the eyes are not covered.
- Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this plan.
- A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net participating vision providers offer discounts of up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

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

Pediatric dental services

Except as described below, all of the following services must be provided by your selected Health Net participating primary dental provider in order to be covered.

Pediatric dental services are covered until the last day of the month in which the individual turns 19 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.

Important: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her 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 to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net Dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review your benefit plan's *Plan Contract and Evidence of Coverage*.

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

Note: For the HSP Minimum Coverage plan, the pediatric dental copayments listed below apply until the calendar year deductible is met. Once the calendar year deductible is met for the HSP Minimum Coverage plan, your copayment is $0 for the noted covered services for the remainder of the calendar year.

Selecting a dentist

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

Step 2: Click on *Find a Dentist* under Links and Tools on the right navigation.

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

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

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

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

Specialist referrals

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

Referrals to specialists for orthodontic care

Each member's primary dentist is responsible for the direction and coordination of the member's complete dental care for benefits. If your primary dentist recommends orthodontic care and you wish to receive benefits for such care under this dental plan, Health Net's Customer Contact Center will assist you in selecting a participating orthodontist from the participating orthodontist directory.

Medically necessary dental services

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

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

Emergency dental services

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

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

Code	Service	Copayment
Diagnostic		
D0120	Periodic oral evaluation – established patient, limited to 1 every 6 months	No charge
D0140	Limited oral evaluation – problem-focused	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge
D0150	Comprehensive oral evaluation – new or established patient	No charge
D0160	Detailed and extensive oral evaluation – problem-focused, by report	No charge
D0170	Re-evaluation – limited, problem-focused (established patient; not post-operative visit), up to six times in a 3-month period and up to a maximum of 12 in a 12-month period 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
D0171	Re-evaluation – post-operative office visit	No charge
D0180	Comprehensive periodontal evaluation – new or established patient	No charge
D0210	X-rays intraoral – complete 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 intraoral – occlusal film – limited to 2 in a 6-month period	No charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector – first film	No charge
D0251	Extraoral posterior dental radiographic image	No charge
D0270	X-rays bitewing – single film – limited to once per date of service	No charge
D0272	X-rays bitewings – two films – limited to once every 6 months	No charge
D0273	X-rays bitewings – three films	No charge
D0274	X-rays bitewings – four films – limited to 1 series 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
D0351	3D photographic image	No charge
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No charge

(continued)

Code	Service	Copayment
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
D0999	Office visit fee – per visit (unspecified diagnostic procedure, by report)	No charge
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
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
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent 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
D1510	Space maintainer – fixed – unilateral, limited to once per quadrant	No charge
D1515	Space maintainer – fixed – bilateral	No charge
D1520	Space maintainer – removable – unilateral, limited to once per quadrant	No charge
D1525	Space maintainer – removable – bilateral	No charge
D1550	Recementation or re-bond of space maintainer	No charge
D1555	Removal of fixed space maintainer	No charge
D1575	Distal shoe space maintainer – fixed – unilateral	No charge
Restorative		
D2140	Amalgam – one surface, primary, limited to once in a 12-month period Amalgam – one surface, permanent, limited to once in a 36-month period	$25 $25
D2150	Amalgam – two surfaces, primary, limited to once in a 12-month period Amalgam – two surfaces, permanent, limited to once in a 36-month period	$30 $30
D2160	Amalgam – three surfaces, primary, limited to once in a 12-month period Amalgam – three surfaces, permanent, limited to once in a 36-month period	$40 $40
D2161	Amalgam – four or more surfaces, primary, limited to once in a 12-month period Amalgam – four or more surfaces, permanent, limited to once in a 36-month period	$45 $45
D2330	Resin-based composite – one surface, anterior primary, limited to once in a 12-month period Resin-based composite – one surface, anterior permanent, limited to once in a 36-month period	$30 $30
D2331	Resin-based composite – two surfaces, anterior primary, limited to once in a 12-month period Resin-based composite – two surfaces, anterior permanent, limited to once in a 36-month period	$45 $45

(continued)

Code	Service	Copayment
D2332	Resin-based composite – three surfaces, anterior primary, limited to once in a 12-month period Resin-based composite – three surfaces, anterior permanent, limited to once in a 36-month period	$55 $55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) primary, limited to once in a 12-month period Resin-based composite – four or more surfaces or involving incisal angle (anterior) permanent, limited to once in a 36-month period	$60 $60
D2390	Resin-based composite crown, anterior, primary, limited to once in a 12-month period Resin-based composite crown, anterior, permanent, limited to once in a 36-month period	$50 $50
D2391	Resin-based composite – one surface, posterior, primary, limited to once in a 12-month period Resin-based composite – one surface, posterior permanent, limited to once in a 36-month period	$30 $30
D2392	Resin-based composite – two surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – two surfaces, posterior, permanent, limited to once in a 36-month period	$40 $40
D2393	Resin-based composite – three surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – three surfaces, posterior, permanent, limited to once in a 36-month period	$50 $50
D2394	Resin-based composite – four or more surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – four or more surfaces, posterior, permanent, limited to once in a 36-month period	$70 $70
Crowns – Single restorations only		
D2710	Crown – resin-based composite (indirect), limited to once in a 5-year period	$140
D2712	Crown – ¾ resin-based composite (indirect), limited to once in a 5-year period	$190
D2721	Crown – resin with predominantly base metal, limited to once in a 5-year period	$300
D2740	Crown – porcelain/ceramic substrate, limited to once in a 5-year period	$300
D2751	Crown – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300
D2781	Crown – ¾ cast predominantly base metal, limited to once in a 5-year period	$300
D2783	Crown – ¾ porcelain/ceramic, limited to once in a 5-year period	$310
D2791	Crown – full cast predominantly base metal, limited to once in a 5-year period	$300
D2910	Recement or re-bond inlay, onlay, or veneer partial coverage restoration, limited to once in a 12-month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2929	Prefabricated porcelain/ceramic crown – primary tooth, limited to once in a 12-month period	$95
D2930	Prefabricated stainless steel crown – primary tooth, limited to once in a 12-month period	$65
D2931	Prefabricated stainless steel crown – permanent tooth, limited to once in a 36-month period	$75

(continued)

Code	Service	Copayment
D2932	Prefabricated resin crown, primary, limited to once in a 12-month period Prefabricated resin crown, permanent, limited to once in a 36-month period	$75 $75
D2933	Prefabricated stainless steel crown with resin window, primary, limited to one in a 12-month period Prefabricated stainless steel crown with resin window, permanent, limited to one in a 36-month period	$80 $80
D2940	Protective restoration, limited to once per tooth in a 12-month period	$25
D2941	Interim therapeutic restoration – primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention – per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated, limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post – same tooth	$30
D2954	Prefabricated post and core in addition to crown, limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post – same tooth	$35
D2971	Additional procedures to construct new crown under existing partial dental framework	$35
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 by the same provider.	$50
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration), removal of pulp coronal to the dentinocemental junction and application of medicament, limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development, limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) – anterior, primary tooth (excluding final restoration), limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration), limited to once per primary tooth	$55
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$195
D3320	Endodontic (root canal) therapy, bicuspid (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (root canal) therapy, molar (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy – anterior	$240
D3347	Retreatment of previous root canal therapy – bicuspid	$295

(continued)

Code	Service	Copayment
D3348	Retreatment of previous root canal therapy – molar	$365
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.), limited to once per permanent tooth	$85
D3352	Apexification/recalcification – interim medication replacement only following D3351, limited to once per permanent tooth	$45
D3410	Apicoectomy anterior	$240
D3421	Apicoectomy bicuspid (first root)	$250
D3425	Apicoectomy molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3427	Periradicular surgery without apicoectomy	$160
D3430	Retrograde filling – per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth spaces per quadrant – once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4341	Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full-mouth, after oral evaluation	$220
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance, limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per member per provider; for members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		
D5110	Complete denture – maxillary, limited to once in a 5-year period from a previous complete, immediate or overdenture-complete denture	$300
D5120	Complete denture – mandibular, limited to once in a 5-year period from a previous complete, immediate or overdenture-complete denture	$300
D5130	Immediate denture – maxillary	$300
D5140	Immediate denture – mandibular	$300

(continued)

Code	Service	Copayment
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$300
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth), limited to once in a 5-year period	$335
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth), limited to once in a 5-year period	$335
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5410	Adjust complete denture – maxillary, limited to once per date of service; twice in a 12-month period	$20
D5411	Adjust complete denture – mandibular, limited to once per date of service; twice in a 12-month period	$20
D5421	Adjust partial denture – maxillary, limited to once per date of service; twice in a 12-month period	$20
D5422	Adjust partial denture – mandibular, limited to once per date of service; twice in a 12-month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth – complete denture (each tooth), limited to a maximum of four per arch, per date of service; twice per arch in a 12-month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials – per tooth – limited to a maximum of three per date of service; twice per arch in a 12-month period	$50
D5640	Replace broken teeth – per tooth – limited to maximum of four per arch, per date of service; twice per arch in a 12-month period	$35
D5650	Add tooth to existing partial denture, limited to a maximum of three per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture – per tooth – limited to a maximum of three per date of service; twice per arch in a 12-month period	$60
D5730	Reline complete maxillary denture (chairside), limited to once in a 12-month period	$60
D5731	Reline complete mandibular denture (chairside), limited to once in a 12-month period	$60
D5740	Reline maxillary partial denture (chairside), limited to once in a 12-month period	$60
D5741	Reline mandibular partial denture (chairside), limited to once in a 12-month period	$60
D5750	Reline complete maxillary denture (laboratory), limited to once in a 12-month period	$90
D5751	Reline complete mandibular denture (laboratory), limited to once in a 12-month period	$90

(continued)

Code	Service	Copayment
D5760	Reline maxillary partial denture (laboratory), limited to once in a 12-month period	$80
D5761	Reline mandibular partial denture (laboratory), limited to once in a 12-month period	$80
D5850	Tissue conditioning, maxillary, limited to twice per prosthesis in a 36-month period	$30
D5851	Tissue conditioning, mandibular, limited to twice per prosthesis in a 36-month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751), and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture – complete maxillary	$300
D5864	Overdenture – partial maxillary	$300
D5865	Overdenture – complete mandibular	$300
D5866	Overdenture – partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial prosthetics		
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification, limited to twice in a 12-month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135

(continued)

Code	Service	Copayment
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification, limited to twice in a 12-month period	$145
D5960	Speech aid prosthesis, modification, limited to twice in a 12-month period	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
Implant services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350
D6055	Connecting bar – implant supported or abutment supported	$350
D6056	Prefabricated abutment – includes modification and placement	$135
D6057	Custom fabricated abutment – includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335

(continued)

Code	Service	Copayment
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, high noble metal)	$330
D6077	Implant-supported retainer for cast metal FPD (titanium, titanium alloy, high noble metal)	$350
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6085	Provisional implant crown	$300
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6096	Removal of broken implant retaining screw	$60
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
Fixed prosthodontics		
D6211	Pontic – cast predominantly base metal, limited to once in a 5-year period	$300
D6241	Pontic – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300
D6245	Pontic – porcelain/ceramic, limited to once in a 5-year period	$300
D6251	Pontic – resin with predominantly base metal, limited to once in a 5-year period	$300
D6721	Retainer crown – resin predominantly base metal – denture, limited to once in a 5-year period	$300
D6740	Retainer crown – porcelain/ceramic, limited to once in a 5-year period	$300
D6751	Retainer crown – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300

(continued)

Code	Service	Copayment
D6781	Retainer crown – ¾ cast predominantly base metal, limited to once in a 5-year period	$300
D6783	Retainer crown – ¾ porcelain/ceramic, limited to once in a 5-year period	$300
D6791	Retainer crown – full cast predominantly base metal, limited to once in a 5-year period	$300
D6930	Recement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral and maxillofacial surgery		
D7111	Extraction, coronal remnants – deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth – soft tissue	$95
D7230	Removal of impacted tooth – partially bony	$145
D7240	Removal of impacted tooth – completely bony	$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Incisional biopsy of oral tissue – hard (bone, tooth), limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue – soft, limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth, permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report, limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization), limited to once in a 5-year period per arch	$350

(continued)

Code	Service	Copayment
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue), limited to once per arch	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible), limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus, limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis, limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity, limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	Incision and drainage of abscess – intraoral soft tissue, limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$70
D7520	Incision and drainage of abscess – extraoral soft tissue	$70
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue, limited to once per date of service	$45
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system, limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone, limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350

(continued)

Code	Service	Copayment
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus – closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – lavage and lysis of adhesions	$350
D7874	Arthroscopy – disc repositioning and stabilization	$350
D7875	Arthroscopy – synovectomy	$350
D7876	Arthroscopy – discectomy	$350
D7877	Arthroscopy – debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350

(continued)

Code	Service	Copayment
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure not incidental to another procedure, limited to once per arch per date of service	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue – per arch, limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity, limited to once per quadrant per date of service	$100
D7979	Non-surgical sialolithotomy	$155
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar, limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
Medically necessary orthodontics		
	Medically necessary banded case (The copayment applies to a member's course of treatment as long as that member remains enrolled in this plan.)	$1,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Recement or re-bond fixed retainer	
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	

(continued)

Code	Service	Copayment
Adjunctive general services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures, limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9222	Deep sedation/general anesthesia – first 15 minutes	$45
D9223	Deep sedation/general anesthesia – each 15-minute increment	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15-minute increment	$60
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	$0
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	$20
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12-month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12-month period per quadrant.	$45
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis – mounted case (D9950)	$210
D9999	Unspecified adjunctive procedure, by report	$0

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. For more information, consult the Health Net *Plan Contract* and *EOC* for your benefit plan.

- 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.
- Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
- 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:
  - Temporomandibular joint treatment (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 procedure.
  - General anesthesia or intravenous/ conscious sedation, except as specified in the medical benefits section.
  - 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 service.
  - Services that were provided without cost to the member by state government or an agency thereof, or any municipality, county or other subdivisions.
  - 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 his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her plan provider is a pedodontist/pediatric dentist.

– Pediatric dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber could reasonably expect that a dental emergency situation did not exist.

Orthodontic benefits

This dental plan covers orthodontic benefits as described above. 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. Orthodontic treatment must be provided by a participating dentist.

Individual & Family plans exclusions and limitations

Exclusions and limitations common to all Individual & Family plans

No payment will be made under the Health Net Individual & Family plans for expenses incurred for, or which are follow-up care to, any of the items below. The following is a selective listing only. For a comprehensive listing, see the Health Net Individual & Family plan *Plan Contract and Evidence of Coverage*. Notwithstanding any exclusions or limitations described below, all medically necessary services for treatment of serious mental illness or serious emotional disturbances of a child mental health conditions shall be covered.

- Services and supplies which Health Net determines are not medically necessary, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net?" earlier in this guide.
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization (HMO) or prior certification (HSP) has been obtained.
- Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.
- Custodial care. Custodial care is not rehabilitative care and is provided to assist a patient in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net determines to be experimental or investigational, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net?" earlier in this guide.
- Services or supplies provided before the effective date of coverage and services or supplies provided after coverage through this plan has ended are not covered.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.[3]

[3]When a medically necessary mastectomy (including lumpectomy) has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infections, tumors, or disease, to do either of the following, improve function or create a normal appearance to the extent possible, it is also covered, unless the surgery offers a minimal improvement in the appearance of the member.

- Treatment and services for temporomandibular joint disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework, and appliances.
- This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center, or other properly licensed medical facility as specified in the plan's *Plan Contract and EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.
- Dental care for individuals ages 19 and older. However, this plan does cover medically necessary 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.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise medically necessary. See the "Dental care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses except as set out under the pediatric dental care program earlier in this guide.
- Services to reverse voluntary surgically induced infertility.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the plan does cover medically necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's *Plan Contract and EOC*.
- Immunizations and injections for foreign travel/occupational purposes.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. When compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan covers durable medical equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (c) surgical dressings other than primary dressings that are applied by your participating provider, physician group or a hospital to lesions of the skin or surgical incisions; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over-the-counter support devices or orthotics, and

devices or orthotics for improving athletic performance or sports-related activities; and (g) orthotics and corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications).

- Personal comfort items.
- Disposable supplies for home use, except certain disposable ostomy or urological supplies. See the *Plan Contract and EOC* for additional information about your plan's benefits.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Treatment by immediate family members.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, a participating provider (medical), the physician group (medical) or the administrator (mental disorders or chemical dependency), according to Health Net's procedures.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drugs, medical equipment or supplies that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs, or for female contraception approved by the FDA).
- Routine foot care, unless prescribed for the treatment of diabetes or peripheral vascular disease.
- Services to diagnose, evaluate or treat infertility are not covered.
- The following fertility preservation services and supplies are not covered: gamete or embryo storage; use of frozen gametes or embryos to achieve future conception; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates).
- Except for services related to behavioral health treatment for pervasive developmental disorder or autism, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the State of California.
- Treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be experimental or investigational in nature. For information regarding requesting an Independent Medical Review of a plan denial of coverage on the basis that it is considered experimental or investigational, see "What if I have a disagreement with Health Net?" earlier in this guide.
- Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity. Certain services may be covered as preventive care services as described in the Health Net Individual & Family *Plan Contract and EOC*.
- Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance

Center. Health Net has a specific network of bariatric facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight-loss surgery. Your physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.

- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.
- Coverage for rehabilitation therapy is limited to medically necessary services provided by a plan-contracted physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorders or autism. Coverage is subject to any required authorization from the plan or the member's medical group. The services must be based on a treatment plan authorized as required by the plan or the member's medical group.
- Coverage for habilitative services and/or therapy is limited to health care services and devices that help a person keep, learn, or improve skills and functioning for daily living, when provided by a member physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of his or her license, to treat physical and mental health conditions, subject to any required authorization from Health Net or your physician group. The services must be based on a treatment plan authorized, as required, by Health Net or your physician group.
- The following types of treatment are only covered when provided in connection with covered treatment for a mental disorder or chemical dependency: (a) treatment for co-dependency; (b) treatment for psychological stress; and (c) treatment of marital or family dysfunction. Treatment of neurocognitive disorders, which include delirium, major and mild neurocognitive disorders and their subtypes, and neurodevelopmental disorders, are covered for medically necessary medical services but covered for accompanying behavioral and/or psychological symptoms or chemical dependency or substance use disorder conditions only if amenable to psychotherapeutic, psychiatric, chemical dependency, or substance use treatment. This provision does not impair coverage for the medically necessary treatment of any mental health conditions identified as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, Text Revision or for medically necessary treatment of SED or SMI as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date. In addition, Health Net will cover only those mental disorder or chemical dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law. This plan covers medically necessary treatment for all essential health benefits, including "mental disorders" described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, Text Revision.
- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy, and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of

coverage, see "What if I have a disagreement with Health Net?" earlier in this guide.

- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain, and as otherwise preauthorized by the administrator.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated, computer-based reports, unless the scoring is performed by a provider qualified to perform it.
- Admission to a residential treatment center that is not medically necessary is excluded. Admissions that are not considered medically necessary and are not covered include, but are not limited to, admissions for custodial care, for a situational or environmental change only, or as an alternative to placement in a foster home or halfway house.
- Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
- Treatment or consultations provided by telephone are not covered.
- Medical, mental health care or chemical dependency services as a condition of parole or probation, and court-ordered testing are limited to medically necessary covered services.
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or physician-directed and is obtained for the purposes of checking a member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment or examinations administered at the request of a third party, such as a school, camp or sports organization.
- The costs associated with participating in sports activities, including, but not limited to, yoga, rock climbing, hiking, and swimming, are not covered.

Additional exclusions and limitations for all HSP plans

- This plan does not cover massage therapy, except when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required, by Health Net.
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by Health Net (medical), the administrator (mental disorders or chemical dependency) or when you require emergency or urgently needed care.

Additional exclusions and limitations for all HMO plans

- This plan does not cover massage therapy, except when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required, by Health Net.
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by your physician group (medical), the administrator (mental disorders or chemical dependency) or when you require emergency or urgently needed care.

Optional dental coverage included with HMO Plus plans and HSP Plus plans (for ages 19 and older)

Principal benefits and coverages for dental care with HMO Plus plans and HSP Plus plans

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

Important: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her 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 to the patient 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.

Selecting a dentist

Step 1
Go to www.yourdentalplan.com/healthnet.

Step 2
Click on *Find a Dentist* under Links and Tools on the right navigation.

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

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

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

You may change your primary dentist once a month. Primary dentist changes made prior to the 15th of the month are effective the first of the following month. Simply select a new dentist from the listing of primary dentists and call Health Net Dental's Customer Contact Center at **1-866-249-2382** with your change. We also offer orthodontic coverage for adults and children. Simply select your orthodontist from the directory at any time during the year.

Copayments

Copayments are your share of costs for covered services and are paid to the dentist at the time of care. Your dental benefits do not have deductibles or any annual maximum dollar benefit limitations. Simply present your Health Net Dental member ID card to the participating primary dentist you selected. It's that simple!

Copayments for dental services benefits under the HMO Plus plans and HSP 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 are:

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

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

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

Summary of dental benefits

Covered benefits		*Member pays*
Deductibles		None
Lifetime maximums		None
Professional services – Diagnostic		
D0120	Periodic oral evaluation – established patient	No charge
D0140	Limited oral evaluation – problem-focused	No charge
D0150	Comprehensive oral evaluation – new or established patient	No charge
D0210	X-rays intraoral – complete series (including bitewings)	No charge
D0220	X-rays intraoral – periapical first film	No charge
D0230	X-rays intraoral – periapical each additional film	No charge
D0240	X-rays intraoral – occlusal film	No charge
D0270	X-rays bitewing – single film	No charge
D0272	X-rays bitewings – two films	No charge
D0273	X-rays bitewings – three films	No charge
D0274	X-rays bitewings – four films Bitewing X-rays are limited to one series of four films in any 12-month period	No charge
D0330	Panoramic film	No charge
D0350	Oral / facial photographic images	No charge
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts	No charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No charge
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No charge
Preventive		
D1110	Prophylaxis – initial	$8
D1110	Prophylaxis – second in same calendar year Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one "second" treatment every 12 months. An additional prophylaxis will be covered if determined to be medically necessary and consistent with professional practices. For example, for high-risk patients, such as women who are pregnant, enrollees undergoing cancer chemotherapy or enrollees with compromising systemic diseases such as diabetes.	$23
D1204	Topical application of fluoride – prophylaxis not included	$3
D1206	Topical fluoride varnish – therapeutic application for moderate to high caries risk patients	$3
D1310	Nutritional counseling for control of dental disease	No charge
D1330	Oral hygiene instructions	No charge
D1510	Space maintainer – fixed, unilateral	$75

(continued)

Covered benefits		*Member pays*
Preventive (continued)		
D1515	Space maintainer – fixed, bilateral	$155
D1520	Space maintainer – removable, unilateral	$100
D1525	Space maintainer – removable, bilateral	$170
D1550	Recementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15
Restorative		
D2140	Amalgam – one surface, permanent	$25
D2150	Amalgam – two surfaces, permanent	$32
D2160	Amalgam – three surfaces, permanent	$41
D2161	Amalgam – four or more surfaces, permanent	$49
D2330	Resin-based composite – one surface, anterior	$35
D2331	Resin-based composite – two surfaces, anterior	$45
D2332	Resin-based composite – three surfaces, anterior	$55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$65
D2391	Resin-based composite – one surface, posterior (permanent tooth)	$55
D2392	Resin-based composite – two surfaces, posterior (permanent tooth)	$70
D2393	Resin-based composite – three surfaces, posterior (permanent tooth)	$85
D2394	Resin-based composite – four or more surfaces, posterior (permanent tooth)	$85
Crowns – single restorations only		
D2710	Crown – resin-based composite, indirect	$240 plus actual lab cost of noble or high noble metal
D2712	Crown – 3/4 resin-based composite, indirect	$240 plus actual lab cost of noble or high noble metal
D2720	Crown – resin with high noble metal	$240 plus actual lab cost of noble or high noble metal
D2721	Crown – resin with predominantly base metal	$240 plus actual lab cost of noble or high noble metal
D2722	Crown – resin with noble metal	$240 plus actual lab cost of noble or high noble metal
D2750	Crown – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D2751	Crown – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D2752	Crown – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal
D2780	Crown – 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal

Covered benefits		*Member pays*
Crowns – single restorations only (continued)		
D2781	Crown – 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2794	Crown – titanium	$280 plus actual lab cost of noble or high noble metal
D2910	Recement inlay, onlay or partial coverage restoration	$15
D2915	Recement cast or prefabricated post and core	$15
D2920	Recement crown	$21
D2930	Prefabricated stainless steel crown – primary tooth	$55
D2931	Prefabricated stainless steel crown – permanent tooth	$65
D2940	Sedative filling	$20
D2950	Core buildup, including any pins	$23 plus actual lab cost of noble or high noble metal
D2951	Pin retention – per tooth, in addition to restoration	$20 plus actual lab cost of noble or high noble metal
D2952	Post and core in addition to crown, indirectly fabricated	$100 plus actual lab cost of noble or high noble metal
D2953	Each additional indirectly fabricated post – same tooth	$100 plus actual lab cost of noble or high noble metal
D2954	Prefabricated post and core	$60 in addition to crown
D2957	Each additional prefabricated post – same tooth	$60
D2970	Temporary crown – fractured tooth	No charge
Endodontics		
D3110	Pulp cap – direct, excluding final restoration	$21
D3120	Pulp cap – indirect, excluding final restoration	$21
D3220	Therapeutic pulpotomy, excluding final restoration – removal of pulp coronal to the dentinocemental junction and application of medicament	$33
D3310	Anterior, excluding final restoration	$170
D3320	Bicuspid, excluding final restoration	$220
D3330	Molar, excluding final restoration	$290
D3332	Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth	$170

(continued)

Covered benefits		*Member pays*
Endodontics (continued)		
D3346	Retreatment of previous root canal therapy – anterior	$185
D3347	Retreatment of previous root canal therapy – bicuspid	$240
D3348	Retreatment of previous root canal therapy – molar	$315
D3410	Apicoectomy/periradicular surgery – anterior	$155
D3421	Apicoectomy/periradicular surgery – bicuspid, first root	$155
D3425	Apicoectomy/periradicular surgery – molar, first root	$155
D3426	Apicoectomy (each additional root)	$75
D3430	Retrograde filling – per root	$48
D3450	Root amputation – per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$85
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded-teeth spaces, per quadrant	$230
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded-teeth spaces, per quadrant	$33
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded-teeth spaces, per quadrant	$30
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded-teeth spaces, per quadrant	$30
D4260	Osseous surgery, including flap entry and closure – four or more contiguous teeth or bounded-teeth spaces, per quadrant	$290
D4261	Osseous surgery, including flap entry and closure – one to three contiguous teeth or bounded-teeth spaces, per quadrant	$290
D4341	Periodontal scaling and root planing – four or more teeth, per quadrant	$30
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$30
D4355	Full-mouth debridement to enable comprehensive evaluation and diagnosis	$20
Prosthodontics (removable) – Dentures replaced within any five-year period are not covered		
D5110	Complete denture – maxillary	$405
D5120	Complete denture – mandibular	$405
D5130	Immediate denture – maxillary	$420
D5140	Immediate denture – mandibular	$420
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$290
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$290
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5410	Adjust complete denture – maxillary	$15
D5411	Adjust complete denture – mandibular	$15
D5421	Adjust partial denture – maxillary	$15
D5422	Adjust partial denture – mandibular	$15
D5510	Repair broken complete denture base	$45

Covered benefits		*Member pays*
Prosthodontics (removable) (continued)		
D5520	Replace missing or broken tooth – complete denture, each tooth	$53
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$58
D5630	Repair or replace broken clasp	$63
D5640	Replace broken teeth – per tooth	$53
D5650	Add tooth to existing partial denture	$58
D5660	Add clasp to existing partial denture	$63
D5710	Rebase complete maxillary denture	$185
D5711	Rebase complete mandibular denture	$185
D5720	Rebase maxillary partial denture	$185
D5721	Rebase mandibular partial denture	$185
D5730	Reline complete maxillary denture – chairside	$70
D5731	Reline complete mandibular denture – chairside	$70
D5740	Reline maxillary partial denture – chairside	$70
D5741	Reline mandibular partial denture – chairside	$70
D5750	Reline complete maxillary denture – laboratory	$120
D5751	Reline complete mandibular denture – laboratory	$120
D5760	Reline maxillary partial denture – laboratory	$120
D5761	Reline mandibular partial denture – laboratory	$120
D5820	Interim partial denture – maxillary	$135
D5821	Interim partial denture – mandibular	$135
D5850	Tissue conditioning – maxillary	$40
D5851	Tissue conditioning – mandibular	$40
Prosthodontics (fixed)		
D6205	Pontic – indirect resin-based composite, excluding molars	$280 plus actual lab cost of noble or high noble metal
D6210	Pontic – cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6211	Pontic – cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6212	Pontic – cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6214	Pontic – titanium	$305 plus actual lab cost of noble or high noble metal
D6240	Pontic – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D6241	Pontic – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D6242	Pontic – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal

(continued)

Covered benefits		*Member pays*
Prosthodontics (fixed) (continued)		
D6710	Crown – indirect resin-based composite	$305 plus actual lab cost of noble or high noble metal
D6750	Crown – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D6751	Crown – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D6752	Crown – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal
D6780	Crown – 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6781	Crown – 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6794	Crown – titanium	$280 plus actual lab cost of noble or high noble metal
D6930	Recement fixed partial denture. Fixed bridgework will be covered only when a removable partial denture cannot satisfactorily restore the case.	$23
D6970	Post and core addition to fixed partial denture retainer, indirectly fabricated	$100 plus actual lab cost of noble or high noble metal
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$60
D6973	Core build up for retainer, including any pins	$23 plus actual lab cost of noble or high noble metal
D6976	Each additional indirectly fabricated post – same tooth	$100 plus actual lab cost of noble or high noble metal
D6977	Each additional prefabricated post – same tooth	$60
D9120	Fixed partial denture sectioning	No charge
Oral and maxillofacial surgery		
D7111	Extraction, coronal remnants – deciduous tooth	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) – each additional tooth	$27

Covered benefits		*Member pays*
Oral and maxillofacial surgery (continued)		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal – exposed roots)	$43
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth – soft tissue	$70
D7230	Removal of impacted tooth – partially bony	$105
D7240	Removal of impacted tooth – completely bony	$135
D7250	Surgical removal of residual tooth roots, cutting procedure	$50
Orthodontics		
D8090	Comprehensive orthodontic treatment of the adult dentition	$1,800
D8210	Removable appliance therapy	$115
D8220	Fixed appliance therapy	$220
D8670	Routine orthodontic visits	$17
Adjunctive general services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$14 (This copay is in addition to specific services copays)
Other services		
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	$11
D9951	Occlusal adjustment – limited, per quadrant	$27
D9952	Occlusal adjustment – complete, per quadrant	$27
D9999	Missed appointments without 24-hour prior notice *The copay for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance, or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member.*	$20
D9999	Transfer of all materials with less than a full-mouth X-ray	No charge
D9999	Transfer of all materials with a full-mouth X-ray	No charge
D9999	Operatory preparation fee (payable per visit in addition to any applicable copays for covered services rendered)	No charge

Occasionally, an instance arises where the general dentist deems that the services of a specialist are required. Health Net can assist the member with a referral to a specialist. However, there is no coverage under the plan for services rendered by a specialist except for orthodontic care.

Principal exclusions and limitations for dental care with HMO Plus plans and HSP Plus plans

All medically necessary services are covered if performed by the member's primary dentist. If services of a dental specialist are required, the member will be responsible for the specialist's fees.

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures or b) is inconsistent with generally accepted standards for dentistry.
- Prophylaxis is limited to: (a) one initial treatment every 12 months and (b) one subsequent treatment every 12 months.
- Fluoride treatment is covered twice in any 12-month period.
- Bitewing X-rays are limited to one series of four films in any 12-month period.
- Full-mouth X-rays are limited to once every 36 months or as needed, consistent with professional practice guidelines.
- Periodontal treatments (subgingival curettage and root planing) are limited to five in any 12-month period.
- Replacement of a restoration is covered only when it is medically necessary.
- Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Partial dentures will be replaced as medically necessary, consistent with professional standards of practice.
- Full upper and/or lower dentures will be replaced as medically necessary, consistent with professional standards of practice.
- Services that, in the opinion of the attending dentist or Health Net, are not medically necessary.
- Any experimental 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.
- Any procedure of implantation.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Elective dentistry and cosmetic dentistry.

- Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
- General anesthesia or intravenous/conscious sedation. However, such services may be covered under the medical services portion of this plan. See the plan's *Plan Contract and EOC* for details.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Prescription medications.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Temporomandibular joint treatment (TMJ).
- Treatment of malignancies, cysts, neoplasms, or congenital malformations.

Dental plan general provisions

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

Orthodontic benefits

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

Principal orthodontic exclusions and limitations

Health Net reserves the right to limit coverage to its choice of participating dentists.

Vision coverage included with HMO Plus plans and HSP Plus plans (for ages 19 and over)

Principal benefits and coverages for Vision provided with HMO Plus plans and HSP Plus plans

Provided by Health Net of California, Inc., Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide vision services benefits. This benefit is included only with HMO Plus plans and HSP Plus plans.

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

Copayments for vision services benefits under the HMO Plus plans and HSP Plus plans:

- Do not accrue toward your annual out-of-pocket maximum;
- If your plan has a calendar year deductible, are not subject to that deductible; and
- If your plan has a calendar year deductible, do not accrue toward that deductible.

Benefits and coverage matrix for vision care provided with HMO Plus plans and HSP 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* 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, as medically necessary	$10 copay
Examination for contact lens Standard contact lens fit and follow-up	Up to $55
Premium contact lens fit and follow-up	You receive 10% off retail
Materials Frames (once every 12 months, $80 allowance)	$0 copay
Standard plastic eyeglass lenses (once every 12 months) Single vision	$40 copay
Bifocal	$40 copay
Trifocal	$40 copay
Lenticular	$40 copay
Standard progressive lenses	$105 copay
Premium progressive lenses	$105 copay, plus 80% of charge, less $120 allowance
Lens options (in addition to standard lenses) UV coating	You receive 20% off retail price
Tint (solid and gradient)	You receive 20% off retail price
Standard plastic scratch-resistant	You receive 20% off retail price
Standard polycarbonate	You receive 20% off retail price
Standard anti-reflective	You receive 20% off retail price
Other add-ons and service	You receive 20% off retail price
Contact lenses (every 12 months) (in lieu of eyeglass lenses; includes material only): Medically necessary contact lenses[1]	$0
Non-medically necessary contact lenses Conventional contact lenses ($80 allowance)	$0 copay, plus 15% off of the balance over the allowance
Disposable contact lenses ($80 allowance)	$0 copay, plus balance over the allowance

Limitation: In accordance with professionally recognized standards of practice, this plan covers one complete vision examination once every 12 months. Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one-time-use benefits. No remaining balance. Examination for contact lenses is in addition to the member's vision examination. There is no additional copayment for a contact lens follow-up visit after the initial fitting examination.

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

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

Vision examination

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

Frames

If the exam indicates the necessity of eyeglasses, this vision plan will cover a frame once every 12 months up to a maximum of $80 retail frame allowance plus 20 percent off the 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, prior authorization by Health Net, 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 HMO Plus plans and Health Net HSP Plus plans

The following vision services and expenses are not covered under the HMO Plus plans and the HSP 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.

Nondiscrimination Notice

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

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc. Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FLY020471EP00 (6/18)

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 shichį́’ yídooltah nínízingo t’áá ná ákódoolnííł. Ákót’éego shíká a’doowoł nínízingo Customer Contact Center hoolyéhíjį’ hodíílnih ninaaltsoos nanitingo bee néého’dolzinígíí hodoonihjį’ bikáá’. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį’ hodíílnih Health Net’s Commercial Contact Center 1-800-522-0088 (TTY: 711). T’áá hó dóó ha’ałchíní (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 cầu 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

FLY017550EH00 (12/17)

Health Net Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150

1-877-609-8711 *(English)*
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)*

Assistance for the hearing and speech impaired
TTY users call 711.

www.MyHealthNetCA.com

BKT023309EP00 (1/19)