Health Net of California, Inc. (Health Net)

Individual & Family Plans

ambetter. FROM health net

Individual & Family Ambetter PPO Plans

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

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

The coverage described in this Disclosure Form shall be consistent with the essential health benefits coverage requirements in accordance with the Affordable Care Act (ACA). The essential health benefits are not subject to any annual dollar limits.

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

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

Health Net Individual & Family Coverage for You and Your Family

Is an Ambetter PPO right for you?

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

In-network – You choose a contracted doctor (or hospital) within our Ambetter PPO network. You can take advantage of reduced out-of-pocket costs when you receive care from a provider who is contracted with Health Net for the Ambetter PPO plans.

Out-of-network – You choose a doctor (or hospital) outside of our Ambetter PPO network. These providers do not have a contract with Health Net for the Ambetter PPO plans. You will incur higher out-of-pocket costs than when you see a provider within our Ambetter PPO Network.

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

Except for urgent care and emergency care, services and supplies provided by providers outside of California are not covered.

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

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

We believe maintaining an ongoing relationship with a Physician who knows you well and whom you trust is an important part of a good health care program. That's why with Ambetter PPO, you are required to select a Primary Care Physician (PCP) for yourself and each member of your family, even though you may go directly to any provider without first seeing your PCP. When selecting a PCP, choose a participating physician close enough to your residence to allow reasonable access to medical care. Information on how to select a PCP and a listing of the participating physicians in the Health Net Ambetter PPO service area, are available on the Health Net website at www.myhealthnetca.com. You can also call 877-609-8711 to request provider information or contact your Health Net authorized broker. PCPs include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

Some of the covered expenses under the Ambetter PPO plan are subject to a requirement of prior authorization in order for a non-authorization penalty to not apply. See the "Prior Authorization Requirements" below.

Calendar year deductible

For some Ambetter PPO plans, a calendar year deductible is required for certain services and is applied to the out-of-pocket maximum. See the benefit grids for specific information. You must pay an amount of covered expenses for noted services equal to the calendar year deductible before the benefits are paid by your plan. After the deductible is satisfied, you remain financially responsible for paying any other applicable copayments until you satisfy the individual or family out-of-pocket maximum. If you are a member in a family of two or more members, you reach the deductible either when you 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.

Any amount applied toward the calendar year deductible for covered services and supplies received from a preferred provider will not apply toward the calendar year deductible for out-of-network providers. In addition, any amount applied toward the calendar year deductible for covered services and supplies received from an out-of-network provider will not apply toward the calendar year deductible for preferred providers. If your plan has a calendar year deductible, that deductible does not apply to adult

dental and vision services benefits under the Ambetter PPO Plus plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" below). In addition, if your plan has a calendar year deductible, copayments for adult dental and vision services benefits under the Ambetter PPO Plus plans do not accrue toward that deductible.

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

Out-of-pocket maximum

Copayments and deductibles that you or your family members pay for covered 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. Any deductible, copayments or coinsurance paid for the services of a preferred provider will not apply toward the out-of-pocket maximum for out-of-network providers. In addition, deductible, copayments, or coinsurance paid for the services of an out-of-network provider will not apply toward the out-of-pocket maximum for preferred providers. Copayments for adult dental and vision services benefits under the Ambetter PPO Plus plans (see "Optional Dental and Vision Coverage (for ages 19 and older)" below) do not accrue toward your OOPM. For the Ambetter PPO plans, penalties paid for services which were not authorized as required do not apply to the yearly OOPM (see the "Prior Authorization Requirements" below). For the family OOPM to apply, you and your family must be enrolled as a family.

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

Prior Authorization Requirements

For Ambetter PPO plans, certain covered services require Health Net's review and approval, called authorization, before they are obtained. If these services are not authorized before they are received, you will be responsible for paying a $250 non-authorization penalty for in-network providers and a $500 non-authorization penalty for out-of-network providers. These penalties do not apply to your out-of-pocket maximum.

We may revise the Prior Authorization list from time to time. Any such changes including additions and deletions from the Prior Authorization list will be communicated to Participating Providers and posted on the www.myhealthnetca.com website. *Prior authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules, and benefit limitations will still apply.* See the Individual & Family *Plan Contract and EOC* for details.

Services that require authorization include:

Inpatient facility admissions[1]

Any type of facility, including but not limited to:

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

Outpatient procedures, services, or equipment

1. Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
2. Acupuncture (after the initial consultation, continued treatment plans may need approval from ASH)
3. Ambulance: non-emergency air or ground ambulance services
4. Bariatric procedures
5. Bronchial thermoplasty
6. Capsule Endoscopy
7. Cardiovascular procedures
8. Clinical Trials
9. Diagnostic procedures including:
   - Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
   - Cardiac Imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Multigated Acquisition (MUGA) scan
     - Myocardial Perfusion Imaging (MPI)
   - Sleep studies
10. Durable Medical Equipment (DME)
11. Ear, Nose and Throat (ENT) procedures
12. Enhanced External Counterpulsation (EECP)
13. Epidural spine injections and single injection trials for intrathecal pumps
14. Experimental/Investigational services and new technologies.
15. Facet joint denervation, injection or blocks
16. Gender affirming services
17. Genetic testing (prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer)
18. Implantable pain pumps including insertion or removal
19. Injections, including trigger point, and sacroiliac (SI) joint injections
20. Joint surgeries
21. Mental Health and Substance Use Disorder services other than office visits including
    - Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
    - Electroconvulsive Therapy (ECT)
    - Half-Day Partial Hospitalization
    - Intensive Outpatient Program (IOP)
    - Neuropsychological testing
    - Partial Hospital Program or Day Hospital (PHP)
    - Psychological testing
    - Transcranial Magnetic Stimulation (TMS)
22. Neuro or spinal cord stimulator
23. Neuropsychological Testing
24. Orthognathic procedures (includes TMJ treatment)
25. Orthotics (custom made items)
26. Pharmaceuticals
    - Outpatient prescription drugs
      - Most specialty drugs, including self-injectable drugs and hemophilia factors, must have prior authorization through the prescription drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Essential Drug List to identify which drugs require prior authorization. Urgent or emergent drugs that are medically necessary to begin immediately may be obtained at a retail pharmacy.
      - Other prescription drugs, as indicated in the Essential Drug List, may require prior authorization. Refer to the Essential Drug List to identify which drugs require prior authorization.
    - Certain physician-administered drugs, including newly approved drugs, whether administered in a physician office, free-standing infusion center, home-infusion, Outpatient Surgical Center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net website, www.myhealthnetca.com, for a list of physician-administered drugs that require prior authorization. Biosimilars are required in lieu of branded drugs, unless medically necessary.
27. Prosthesis
28. Quantitative drug testing
29. Radiation therapy
30. Reconstructive and cosmetic surgery, services, and supplies such as:
    - Bone alteration or reshaping such as osteoplasty

- Breast reductions and augmentations except when following a mastectomy (includes mastectomy for gynecomastia)
- 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.
- Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
- 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
- Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
- Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
- Hair electrolysis, transplantation, or laser removal
- Lift such as arm, body, face, neck, thigh
- Liposuction
- Nasal surgery such as rhinoplasty or septoplasty
- Otoplasty
- Penile implant
- Treatment of varicose veins
- Vermilionectomy with mucosal advancement

31. Spinal surgery
32. Sympathetic nerve blocks
33. Testosterone therapy
34. Therapy (includes home setting)
    - Occupational therapy
    - Physical therapy
    - Speech therapy
35. Transplant and related services
36. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
37. Vestibuloplasty
38. Wound care

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

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

When you receive care from an out-of-network provider, your share of cost is based on MAA. You are responsible for any applicable deductible, copayments or coinsurance payment, **and** any amounts billed in excess of MAA. You are completely financially responsible for care that this plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Health Net calculates MAA as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth below. MAA is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable deductibles, copayments or coinsurance and other applicable amounts set forth in the *Plan Contract and EOC*.

MAA for covered services and supplies, excluding emergency care and outpatient pharmaceuticals, received from an out-of-network provider is a percentage of what Medicare would pay, known as the Medicare allowable amount.

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

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

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

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

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

a. MAA for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with preferred providers within the geographic region for the same covered services or supplies provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare allowable amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the out-of-network provider's billed charges for covered services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. MAA for facility services shall be the lesser of: (1) the average amount negotiated with preferred providers within the geographic region for the same covered services or supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare allowable amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the out-of-network provider's billed charges for covered services.

MAA for out-of-network emergency care will be a combined calculation of the following, as applicable: (1) the median of the amounts negotiated with preferred providers for the emergency service provided, excluding any in-network copayment or coinsurance; (2) the amount calculated using the same method Health Net generally uses to determine payments for out-of-network providers, excluding any in-network deductible, copayment or coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance. Emergency care from an out-of-network provider is subject to the applicable deductible, copayment and/or coinsurance at the preferred provider benefit level. You are not responsible for any amount that exceeds MAA for emergency care.

MAA for non-emergent services at an in-network health facility, at which, or as a result of which, You receive non-emergent covered services by an out-of-network provider, the non-emergent services provided by an out-of-network provider will be payable at the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.

MAA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, physician office, outpatient hospital facilities, and services in the patient's home, will be the lesser of billed charges or the average wholesale price for the drug or medication.

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

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

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

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

Claims payment will also never exceed the amount the out-of-network provider charges for the service or supply. You should contact the Customer Contact Center if you wish to confirm the covered expenses for any treatment or procedure you are considering.

Timely Access to Care to Preferred Providers

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

You may contact Health Net at the number shown on the back cover, 7 days 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 Ambetter PPO *Plan Contract and EOC* or contact the Health Net Customer Contact Center at the phone number on the back cover.

Please see the "Notice of Language Services" at the end of this *disclosure form* for information regarding the availability of no-cost interpreter services.

Optional Dental and Vision Coverage (for ages 19 and older)[2]

The Health Net Individual & Family Plans include pediatric dental and vision coverage for individuals under 19 years of age. Optional dental and vision coverage for ages 19 and older is available with Health Net Ambetter PPO Plus plans. A Health Net "Plus" plan is a Health Net Ambetter PPO plan with Health Net dental and vision coverage included.

The "Plus" indicates the addition of the optional coverage. For more information, refer to the Plus plan information found later in this guide or contact your authorized Health Net agent or call Health Net's Individual & Family Plans Department at 800-909-3447.

[2]Dental and vision benefits for PPO plans are provided by Health Net of California, Inc. Dental benefits administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net of California, Inc. Health Net contracts with Centene Vision Services to provide and administer vision benefits.

Health Net of California Inc. (Health Net)

California Individual & Family Plans
Available directly through Health Net

Platinum 90 Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered 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 (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	None	$5,000 single / $10,000 family
Out-of-pocket maximum[5]	$4,500 single / $9,000 family	$25,000 single / $50,000 family
Professional services Office visit	$15	50%
Telehealth consultations through the select telehealth services provider[6]	$0	Not covered
Specialist consultation	$30	50%
Medically necessary acupuncture	$15	Not covered
Preventive care services[7]	$0	Not covered
X-ray and diagnostic imaging	$30	50%
Laboratory procedures	$15	50%
Imaging (CT/PET scans, MRIs)	10%	50%
Rehabilitation and habilitation therapy	$15	Not covered
Outpatient services Outpatient surgery	10%	50%
Hospital services Inpatient hospital facility services (includes maternity)	10%	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	10%	50%
Emergency services Emergency room services (copays waived if admitted)	Facility: $150; Physician: $0	Facility: $150 (ded. waived); Physician: $0 (ded. waived)
Urgent care	$15	50%
Ambulance services (ground and air)	$150	Payable at the Preferred Provider level of benefits (ded. waived)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	10%	50%
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $15 Other than office visit: 10% up to $15	50%
Home health care services (100 visits/year)	10%	Not covered
Other services Durable medical equipment	10%	Not covered
Hospice service	$0	50%

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[8] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$7	Not covered
Tier 2 (non-preferred generics and preferred brands)	$16	Not covered
Tier 3 (non-preferred brands)	$25	Not covered
Tier 4 (Specialty drugs)	10% up to $250 / 30-day script	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9,11] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

THIS IS A SUMMARY OF BENEFITS. IT DOES NOT INCLUDE ALL SERVICES, LIMITATIONS OR EXCLUSIONS. PLEASE REFER TO THE *PLAN CONTRACT AND EOC* FOR TERMS AND CONDITIONS OF COVERAGE.

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

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

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

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

[5]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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

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

[8]The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

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

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

[11]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Health Net of California Inc. (Health Net)

California Individual & Family Plans
Available directly through Health Net

Gold 80 Ambetter PPO

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

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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 (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	None	$5,000 single / $10,000 family
Out-of-pocket maximum[5]	$8,700 single / $17,400 family	$25,000 single / $50,000 family
Professional services Office visit	$35	50%
Telehealth consultations through the select telehealth services provider[6]	$0	Not covered
Specialist consultation	$65	50%
Medically necessary acupuncture	$35	Not covered
Preventive care services[7]	$0	Not covered
X-ray and diagnostic imaging	$75	50%
Laboratory procedures	$40	50%
Imaging (CT/PET scans, MRIs)	25%	50%
Rehabilitation and habilitation therapy	$35	Not covered
Outpatient services Outpatient surgery	30%	50%
Hospital services Inpatient hospital facility services (includes maternity)	30%	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30%	50%
Emergency services Emergency room (copayment waived if admitted)	Facility: $330; Physician: $0	Facility: $330 (ded. waived); Physician: $0 (ded. waived)
Urgent care	$35	50%
Ambulance services (ground and air)	$250	Payable at the Preferred Provider level of benefits (ded. waived)
Mental/Behavioral health/Substance use disorder services Mental/Behavioral health/Substance use disorder (inpatient)	30%	50%
Mental/Behavioral health/Substance use disorder (outpatient)	Office visit: $35 Other than office visit: 20% up to $35	50%
Home health care services (100 visits/year)	20%	Not covered
Other services Durable medical equipment	20%	Not covered
Hospice service	$0	50%

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage[8] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$15	Not covered
Tier 2 (non-preferred generics and preferred brands)	$60	Not covered
Tier 3 (non-preferred brands)	$85	Not covered
Tier 4 (Specialty drugs)	20% up to $250 / 30-day script	Not covered
Pediatric dental[9,10] Diagnostic and preventive services	$0	Not covered
Pediatric vision[9,11] Eye exam	$0	Not covered
Glasses	1 pair per year – $0	Not covered

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

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

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

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

[5]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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

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

[8]The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

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

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

[11]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Silver 70 Off Exchange Ambetter PPO

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

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Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	$5,400 single / $10,800 family	$10,800 single / $21,600 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$8,700 single / $17,400 family	$25,000 single / $50,000 family
Professional services Office visit	$50 (ded. waived)	50%
Telehealth consultations through the select telehealth services provider[6]	$0 (ded. waived)	Not covered
Specialist consultation	$90 (ded. waived)	50%
Medically necessary acupuncture	$50 (ded. waived)	Not covered
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging	$95 (ded. waived)	50%
Laboratory procedures	$50 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	$325 (ded. waived)	50%
Rehabilitation and habilitation therapy	$50 (ded. waived)	Not covered
Outpatient services Outpatient surgery	30% (ded. waived)	50%
Hospital services Inpatient hospital facility services (includes maternity)	Facility: 30%;[8] Physician: 30% (ded. waived)[8]	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30%	50%
Emergency services Emergency room (copayment waived if admitted)	Facility: $400 (ded. waived); Physician: $0 (ded. waived)	Facility: $400 (ded. waived); Physician: $0 (ded. waived)
Urgent care	$50 (ded. waived)	50%
Ambulance services (ground and air)	$255 (ded. waived)	Payable at the Preferred Provider level of benefits (ded. waived)
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 30%[8]; Physician: 30% (ded. waived)[8]	50%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $50 (ded. waived) Other than office visit: 30% up to $50 (ded. waived)	50%
Home health care services (100 visits/year)	$45 (ded. waived)	Not covered
Other services Durable medical equipment	20% (ded. waived)	Not covered
Hospice service	$0 (ded. waived)	50%

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Prescription drug coverage Prescription drug calendar year deductible (per insured)	$50 single / $100 family	Not covered
Prescription drugs[9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$18 (Rx ded. waived)	Not covered
Tier 2 (non-preferred generics and preferred brands)	$60 (after Rx deductible)	Not covered
Tier 3 (non-preferred brands)	$90 (after Rx deductible)	Not covered
Tier 4 Specialty drugs (most self-injectables)	20% up to $250 / 30-day script (after Rx deductible)	Not covered
Pediatric dental[10,11] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[10,12] Eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

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

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

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

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

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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

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

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

[9] The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

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

[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 not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

[12] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Health Net of California Inc. (Health Net)

California Individual & Family Plans
Available directly through Health Net

Bronze 60 Ambetter PPO

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

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Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	$5,800 single / $11,600 family	$11,600 single / $23,200 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$8,850 single / $17,700 family	$25,000 single / $50,000 family
Professional services Office visit	$60 (ded. waived)	50%
Telehealth consultations through the select telehealth services provider[7]	$0 (ded. waived)	Not covered
Specialist consultation	Visits 1–3: $95 (ded. waived) / Visits 4+: $95 (ded. applies)[6]	50%
Medically necessary acupuncture	$60 (ded. waived)	Not covered
Preventive care services[8]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging	40%[9]	50%
Laboratory procedures	$40 (ded. waived)	50%
Imaging (CT/PET scans, MRIs)	40%[9]	50%
Rehabilitation and habilitation therapy	$60 (ded. waived)	Not covered
Outpatient services Outpatient surgery	40%[9]	50%
Hospital services Inpatient hospital facility services (includes maternity)	40%[9]	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	40%[9]	50%
Emergency services Emergency room (copayment waived if admitted)	Facility: 40%[9]; Physician: $0 (ded. waived)	Facility: 40%[9]; Physician: $0 (ded. waived)
Urgent care	$60 (ded. waived)	50%
Ambulance services (ground and air)	40%[9]	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	40%[9]	50%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $60 (ded. waived) Other than office visit: 40% up to $60 (ded. waived)	50%
Home health care services (100 visits/year)	40%[9]	Not covered
Other services Durable medical equipment	40%[9]	Not covered
Hospice service	$0 (ded. waived)	50%

Benefit description	Member(s) responsibility	
	In-network[1,2]	**Out-of-network**[1,3]
Prescription drug coverage[10] Prescription drug calendar year deductible (per insured)	$450 single / $900 family	Not covered
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brands)	$19 / 30-day script (Rx ded. waived)	Not covered
Tier 2 (non-preferred generics and preferred brands) Tier 3 (non-preferred brands) Tier 4 (Specialty drugs)	40% up to $500 / 30-day script (after Rx deductible)[11]	Not covered
Pediatric dental[12,13] Diagnostic and preventive services	$0 (ded. waived)	Not covered
Pediatric vision[12,14] Eye exam	$0 (ded. waived)	Not covered
Glasses	1 pair per year – $0 (ded. waived)	Not covered

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

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

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

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

[5] Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[6] Bronze 60 plan: The calendar year deductible applies after the first 3 non-preventive specialist visits.

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

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

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

[10] The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

[11] Bronze 60 plan: After the pharmacy deductible has been reached, the member will be responsible for 40% of the cost of all Tier 2, 3, and 4 drugs up to a maximum payment of $500 for each prescription of up to a 30-day supply, until the out-of-pocket maximum limit is met.

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

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

[14] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Health Net of California Inc. (Health Net)

California Individual & Family Plans Available directly through Health Net

Bronze 60 HDHP Ambetter PPO

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

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Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	$6,650 single / $13,300 family	$13,300 single / $26,600 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$6,650 single / $13,300 family	$25,000 single / $50,000 family
Professional services Office visit	0%	50%
Telehealth consultations through the select telehealth services provider[6]	0%	Not covered
Specialist consultation	0%	50%
Medically necessary acupuncture	0%	Not covered
Preventive care services[7]	$0 (ded. waived)	Not covered
X-ray and diagnostic imaging	0%	50%
Laboratory procedures	0%	50%
Imaging (CT/PET scans, MRIs)	0%	50%
Rehabilitation and habilitation therapy	0%	Not covered
Outpatient services Outpatient surgery	0%	50%
Hospital services Inpatient hospital facility services (includes maternity)	0%	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0%	50%
Emergency services Emergency room (copayment waived if admitted)	Facility: 0%; Physician: 0%	Facility: 0%; Physician: 0%
Urgent care	0%	50%
Ambulance services (ground and air)	0%	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	0%	50%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: 0% Other than office visit: 0%	50%
Home health care services (100 visits/year)	0%	Not covered
Other services Durable medical equipment	0%	Not covered
Hospice service	0%	50%

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

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

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

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

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

[5]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

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

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

[8]The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

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

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

[11]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Minimum Coverage Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered 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 (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

Benefit description	Member(s) responsibility	
	In-network[1,2]	Out-of-network[1,3]
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.		
Plan maximums Calendar year deductible[4]	$9,200 single / $18,400 family	$18,400 single / $36,800 family
Out-of-pocket maximum (includes calendar year deductible)[5]	$9,200 single / $18,400 family	$25,000 single / $50,000 family
Professional services Office visit	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	50%
Telehealth consultations through the select telehealth services provider[7]	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	Not covered
Specialist consultation	0%	50%
Medically necessary acupuncture	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	Not covered
Preventive care services[8]	$0 (ded. waived)	Not covered
Laboratory procedures, X-ray and diagnostic imaging	0%	50%
Rehabilitation and habilitation therapy	0%	Not covered
Outpatient services Outpatient surgery	0%	50%
Hospital services Inpatient hospital facility services (includes maternity)	0%	50%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0%	50%
Emergency services Emergency room (copayment waived if admitted)	0% facility / 0% physician (ded. waived)	0% facility / 0% physician (ded. waived)
Urgent care	Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]	50%
Ambulance services (ground and air)	0%	Payable at the Preferred Provider level of benefits
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	0%	50%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6] Other than office visit: 0%	50%
Home health care services (100 visits/year)	0%	Not covered
Other services Durable medical equipment	0%	Not covered
Hospice service	0%	50%

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

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

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

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

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

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

[5]Copayments or coinsurance paid for in-network services will not apply toward the out-of-pocket maximum for out-of-network providers, and coinsurance paid for out-of-network services will not apply toward the out-of-pocket maximum for preferred providers. Copayments or coinsurance for out-of-network emergency care, including emergency room and ambulance services, accrues to the out-of-pocket maximum for preferred providers.

[6]Minimum Coverage plan: Visits 1 -3 (combined between primary care office visits, urgent care, and other practitioner non-physician provider office visits, including acupuncturists, outpatient mental health/substance abuse): The calendar year deductible is waived. Visits 4 -unlimited: The calendar year deductible applies.

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

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

[9]The Essential Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity. For a copy of the Essential Drug List, which you can use to search for a particular drug, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.myhealthnetca.com.

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

[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 not affiliated with Health Net of California, Inc. See the *Plan Contract and EOC* for pediatric dental benefit details.

[12]The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with Centene Vision Services to administer the pediatric vision services benefits.

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Important Things to Know About Your Medical Coverage

How to apply

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

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

If you are completing a paper application:

- Make sure you choose a primary care physician. Finding a PCP is easy with Health Net's doctor search. To find the most up-to-date list, log on to www.myhealthnetca.com > *Find a Doctor.*

  You'll find a complete listing of our Individual & Family Plan network physicians, and you can search specialty, city, county, or doctor's name. You can also call 800-909-3447 to request provider information or contact your Health Net authorized broker.
- Sign and date the application. (Each person over the age of 18 listed on the application must sign and date the application.)
- Include a check payable to Health Net for the applicable premium payment.
- Mail the completed application and check (within 30 days of signature date) to your authorized Health Net agent or to:

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

Who is eligible?

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

For 2025 enrollment takes place November 1, 2024, to January 31, 2025, inclusive.

Note: Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with permanent kidney failure. If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications.

You can get free counseling regarding your Medicare eligibility and enrollment options by calling the Health Insurance Counseling and Advocacy Program (HICAP) at 800-434-0222. Visit www.cahealthadvocates.org/hicap to find a HICAP office near you.

Special enrollment periods

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

- Gained, lost or changed dependent status due to marriage, domestic partnership, divorce, legal separation, dissolution of domestic partnership, birth, adoption, placement for adoption, coverage mandated by a valid state or federal court order, or assumption of a parent/stepparent-child relationship;
- Were mandated to be covered as a dependent due to a valid state or federal court order;
- Were released from incarceration;
- Demonstrate that you had a material provision of your health coverage contract substantially violated by your health coverage issuer;
- Gained access to new health benefit plans as a result of a permanent move;
- Were receiving services under another health benefit plan from a contracting provider who no longer participates in that health plan for any of the following conditions: (a) an acute or serious condition; (b) a terminal illness; (c) a pregnancy; (d) care of a

newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the 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 the Exchange.
- Are a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, 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;
- Gain access to the Individual Coverage Health Reimbursement Arrangement (ICHRA) and are not already covered by the ICHRA.

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

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

Domestic partner

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

How does the monthly billing work?

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

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

Can benefits be terminated?

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

- You do not pay your premium on time. (Health Net will issue a 30-day prior notice of our right to terminate your coverage for non-payment of premium. The 30-day prior notice will be sent on or

before the first day of the month for which premiums are due and will describe the 30-day grace period, which 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;
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 **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 your health plan, you should first telephone your health plan at **800-839-2172** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for 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 **888-466-2219** and a **TDD** line **877-688-9891** for the hearing and speech impaired. The department's Internet website, **www.dmhc.ca.gov,** has complaint forms, IMR application forms and instructions online.

What are Health Net's premium ratios?

Health Net of California's 2023 ratio of premium costs to health services paid for Individual & Family PPO plans was 88.1 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?

Health Net will make every effort to ensure that care continues. You may request continued care from an out-of-network provider at the in-network benefit level if, at the time of contract termination, you were receiving care from such a provider for the conditions listed below.

For providers and hospitals that end their contract with Health Net, a written notice will be provided to members with open authorizations within five days after the effective date of the contract termination.

If Health Net's contract with a preferred provider is terminated, Health Net may provide coverage for completion of services at the in-network benefit level from a provider whose contract has ended, subject to applicable deductible, copayments or coinsurance and any other exclusions and limitations of your plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination, unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as it is reasonably possible.

The following conditions are eligible for continuation of care:

- An acute condition;
- A serious chronic condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A terminal illness (for the duration of the terminal illness); or

- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

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

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

- An acute condition;
- A serious chronic condition not to exceed twelve months from the member's effective date of coverage under this plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from your effective date of coverage under this plan;
- A terminal illness (for the duration of the terminal illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

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

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 800-522-0088 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

Health Net pays preferred providers on a fee-for-service basis, according to an agreed contracted rate. Members may request more information about our payment methods by contacting Health Net's Customer Contact Center at the telephone number on the back of their Health Net ID card.

When and how does Health Net pay my medical bills and am I liable for payment of certain services?

Covered services or supplies from preferred providers are paid at the in-network benefit level. The maximum amount of covered expenses for a service or supply provided by a preferred provider is the lesser of the billed charge or the contracted rate. You will not be responsible for any amount billed in excess of the contracted rate. However, you are responsible for any applicable deductible, copayments or coinsurance payment. You are always responsible for services or supplies not covered by this plan.

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

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

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

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

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

For information regarding Health Net payment for out-of-network emergency care, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section.

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

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

Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Active labor means labor at the time that either of the following could reasonably be expected to occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery or (b) a transfer poses a threat to the health and safety of the member or 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 their license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capacity of the facility or by transferring the member to a psychiatric unit within a

general acute hospital or to an acute psychiatric hospital as medically necessary.

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

If, once your emergency medical condition or psychiatric emergency medical condition is stabilized, and your treating health care provider at the hospital believes that you require additional medically necessary hospital services, the hospital must contact Health Net to obtain timely prior authorization, or you will be subject to the non-authorization penalty. If you want to be transferred from an out-of-network hospital to a preferred provider hospital, and Health Net determines that you may be safely transferred, Health Net will arrange for the transfer and for the care to continue at the preferred provider hospital.

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

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

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

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

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

We shall not disclose medical information related to sensitive services provided to a protected individual to the subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

How does Health Net deal with new technologies?

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices. New technologies are considered investigational 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 prior authorization, concurrent and retrospective review, and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. This oversight helps to maintain Health Net's high quality medical management standards.

Prior authorization

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

Concurrent review

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

Discharge planning

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

Retrospective review

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

Care or case management

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

Additional Product Information

Mental health and substance use disorders

You may obtain mental health and substance use disorder services from any behavioral health provider. To obtain care at the in-network benefit level, contact the Health Net Customer Contact Center at the phone number on the back cover. Health Net will help you identify a nearby participating behavioral health professional with whom you can make an appointment.

Certain services and supplies for mental health and substance use disorders may require prior authorization by Health Net in order to be covered.

Please refer to the Health Net Individual & Family *Plan Contract and EOC* for a more complete description of mental health and substance use disorder services and supplies, including those that require prior authorization by Health Net.

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Net fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an Out-of-Network Provider. If that happens, you do not have to pay anything other than your ordinary in-network cost sharing.

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

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

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

Telehealth consultations through the select telehealth services provider

Health Net contracts with certain select telehealth services providers to provide telehealth services for medical, mental health and substance use disorder conditions. The designated select telehealth services provider for this plan is listed on your Health Net ID card. To obtain services, contact the select telehealth services provider directly as shown on your ID card. Services from the select telehealth services provider are not intended to replace services from your physician, but are a supplemental service that may provide telehealth coverage for certain services at a lower cost. You are not required to use the Health Net select telehealth services provider for telehealth services.

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

Prescription drug program

You must purchase covered drugs at a participating pharmacy in the Health Net Ambetter Pharmacy Network except for emergency or urgently needed care. Not all pharmacies that contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency or urgently needed care, only those pharmacies specifically identified as participating in the Ambetter Pharmacy Network may provide the prescription drugs benefit under this plan. For a list of pharmacies participating in the Ambetter Pharmacy Network, call our Health Net Customer Contact Center or visit our website at www.myhealthnetca.com. Pharmacies that are not in the Ambetter Pharmacy Network are considered out-of-network pharmacies under this plan

Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription for covered prescription drugs.

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

Prescription Drug Deductible

The prescription drug deductible (per calendar year) must be paid before Health Net begins to pay. If you are a member in a family of two or more members, you reach the prescription drug deductible either when you meet the amount for any one member, or when your entire family reaches the family amount.

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

Preventive Drugs

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member, and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Over-the-counter preventive drugs, except for over-the-counter contraceptives, which are covered under this plan require a prescription drug order. You must present the prescription drug order at a Health Net Participating Pharmacy to obtain such drugs. Over-the-counter contraceptives that are covered under this plan do not require a prescription drug order but must be obtained from a Health Net Participating Pharmacy at the prescription drug counter. Covered contraceptives are FDA-approved contraceptives that are either available over the counter or are available with a prescription.

Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. Generic drugs will be dispensed when a generic drug equivalent is available. However, if a brand-name preventive drug or contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives and condoms are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

Maintenance prescriptions by mail order drug program

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

Maintenance drugs are prescription drugs taken continuously to manage chronic or long-term conditions where members respond positively to drug treatment. The mail order administrator may only dispense up to a 90-consecutive-calendar-day supply of a covered maintenance drug and each refill allowed by that order. 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 **800-522-0088 or contact us at www.myhealthnetca.com.**

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

The Health Net Essential Drug List: Tier 1 drugs (most generic drugs and low cost preferred brand name drugs) and Tier 2 drugs (non-preferred generic, preferred brand name drugs, and drugs recommended by Health Net's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost).

The Health Net Essential Drug List (or Formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain affordable pharmacy benefits. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier 3 copayment if the member's physician demonstrates medical necessity.

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

The Essential 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 Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

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

Tier 3 drugs

Tier 3 drugs include non-preferred brand name drugs, or drugs that are recommended by Health Net's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 drugs (Specialty drugs)

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

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

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

Step Therapy

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

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the prescription drug prescribed by a health care provider for a member. For more information on the step therapy exception process, please see "Step Therapy Exception" in the Essential Drug List on **www.myhealthnetca.com.**

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

What is "prior authorization"?

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

The criteria used for prior authorization or step therapy are developed and based on input from the 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.

Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers are notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted.

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

Prescription drug program exclusions and limitations

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

- Allergy serum is covered as a medical benefit.
- Brand-name drugs that have generic equivalents are not covered without prior authorization from Health Net.
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers, and diabetic supplies. No other devices are covered even if prescribed by a participating physician.

- Drugs prescribed for the treatment of obesity are not covered, except when medically necessary for the treatment of morbid obesity or when you meet Health Net prior authorization coverage requirements. The prescribing physician must request and obtain prior authorization for coverage.
- Drugs prescribed to shorten the duration of the common cold.
- Experimental drugs (those that are labeled "Caution – Limited by federal law to investigational 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 and pen needles.
- 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 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 and on the Essential Drug List for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period.

- Prescription drugs prescribed to a surrogate, including a member and/or family member acting as a surrogate or utilizing the services of a surrogate who may or may not be a member and/or family member, and any child born as a result of a surrogacy arrangement.

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

Acupuncture care program

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

ASH Plans will arrange covered acupuncture services for you. You may access any contracted acupuncturist without a referral from a participating provider, physician or your PCP.

You may receive covered acupuncture services from any contracted acupuncturist, and you are not required to pre-designate a contracted acupuncturist prior to your visit from whom you will receive covered acupuncture services. You must receive covered acupuncture services from a contracted acupuncturist, except that:

- If covered acupuncture services are not available and accessible to you in the county in which you live, you may obtain covered acupuncture services from a non-contracted acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered Acupuncture Services may be subject to verification of medical necessity by ASH Plans except:

- A new patient examination by a contracted acupuncturist and the provision or commencement, in the new patient examination, of medically necessary services that are covered acupuncture services, to the extent consistent with professionally recognized standards of practice.

Acupuncture care program exclusions and limitations

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

- Auxiliary aids and services are not covered;
- Services provided by an acupuncturist practicing outside California are not covered;
- Diagnostic radiology, including MRIs or thermography are not covered;
- X-rays, laboratory tests and X-ray second opinions 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 Contract and EOC*.

Pediatric vision care program

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

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

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

Pediatric vision care program exclusions and limitations

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

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

Vision Services Benefits	Copayment
Routine eye exam limit: 1 per calendar year **Exam options:** • Standard contact lens fit including follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions) • Premium contact lens fit including follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)	$0, deductible waived
Lenses limit: 1 pair per calendar year Including: • Single vision, bifocal, trifocal, lenticular • Glass or plastic, including polycarbonate • Oversized and glass-grey #3 prescription sunglass lenses	$0, deductible waived
Provider selected frames limit: 1 per calendar year	$0, deductible waived
Optional lenses and treatments Including: • UV treatment • Tint (fashion & gradient & glass-grey) • Standard plastic scratch coating • Photochromic / transitions plastic • Polarized • Standard, premium, select, and ultra progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses • Select or ultra-progressive lenses • Premium progressive lens	$0, deductible waived
Provider selected contact lenses, a one year supply is covered every calendar year (in lieu of eyeglass lenses) • Disposables • Conventional • Medically necessary[3]	$0, deductible waived
Subnormal or low vision services and aids – one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers, or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years)	$0, deductible waived

[3]Medically necessary contact lenses:

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

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

Medically necessary contact lenses are dispensed in lieu of other eyewear.

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

- Covered services and supplies provided by a provider who is not a participating vision provider;
- Orthoptic or vision training;
- Charges for services and materials that Health Net determines to be non-medically necessary services, are excluded. One routine eye examination with dilation is covered every calendar year, and is not subject to medical necessity.

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

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

Pediatric dental services

All of the following services must be provided by a Health Net Participating Dental Provider in order to be covered.

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

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

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

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

Benefit Description

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Code	Service	Member cost share
Diagnostic		
D0120	Periodic oral evaluation – established patient limited to 1 every 6 months	No charge
D0140	Limited oral evaluation – problem focused	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge
D0150	Comprehensive oral evaluation – new or established patient	No charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No charge
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12 month period	No charge
D0171	Re-evaluation – post-operative office visit	No charge
D0180	Comprehensive periodontal evaluation – new or established patient	No charge
D0210	X-rays intraoral – comprehensive series (including bitewings) limited to once per provider every 36 months	No charge
D0220	X-rays intraoral – periapical first film limited to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.	No charge
D0230	X-rays intraoral – periapical each additional film limited to a maximum of 20 periapicals in a 12 month period	No charge
D0240	X-rays intraoral – occlusal film limited to 2 in a 6 month period	No charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector – first film	No charge
D0251	Extraoral posterior dental radiographic image	No charge
D0270	X-rays bitewing – single film limited to once per date of service	No charge
D0272	X-rays bitewings – two films limited to once every 6 months	No charge
D0273	X-rays bitewings – three films	No charge
D0274	X-rays bitewings – four films – limited to once every 6 months	No charge
D0277	Vertical bitewings – 7 to 8 films	No charge
D0310	Sialography	No charge
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No charge
D0322	Tomographic survey limited to twice in a 12 month period	No charge
D0330	Panoramic film limited to once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery)	No charge
D0340	2D cephalometric radiographic image limited to twice in a 12 month period per provider	No charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No charge
D0396	3D printing of a 3D dental surface scan	No charge
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No charge
D0502	Other oral pathology procedures, by report	No charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge
D0701	Panoramic radiographic image – image capture only	No charge
D0702	2-D cephalometric radiographic image – image capture only	No charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	No charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No charge
D0706	Intraoral – occlusal radiographic image – image capture only	No charge
D0707	Intraoral – periapical radiographic image – image capture only	No charge
D0708	Intraoral – bitewing radiographic image – image capture only	No charge
D0709	Intraoral – series of radiographic images – image capture only	No charge
D0801	3D dental surface scan - direct	No charge
D0802	3D dental surface scan - indirect	No charge
D0803	3D facial surface scan - direct	No charge
D0804	3D facial surface scan - indirect	No charge
D0999	Office visit fee – per visit (Unspecified diagnostic procedure, by report)	No charge

(continued)

Code	Service	Member cost share
Preventive		
D1110	Prophylaxis – adult limited to once in a 12 month period	No charge
D1120	Prophylaxis – child limited to once in a 6 month period	No charge
D1206	Topical fluoride varnish limited to once in a 6 month period	No charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6 month period	No charge
D1310	Nutritional counseling for control of dental disease	No charge
D1320	Tobacco counseling for the control and prevention of oral disease	No charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high–risk substance use	No charge
D1330	Oral hygiene instructions	No charge
D1351	Sealant – per tooth limited to first, second and third permanent molars that occupy the second molar position	No charge
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
D1355	Caries preventive medicament application – per tooth	No charge
D1510	Space maintainer – fixed – unilateral limited to once per quadrant	No charge
D1516	Space maintainer – fixed – bilateral, maxillary	No charge
D1517	Space maintainer – fixed – bilateral, mandibular	No charge
D1520	Space maintainer – removable – unilateral limited to once per quadrant	No charge
D1526	Space maintainer – removable – bilateral, maxillary	No charge
D1527	Space maintainer – removable – bilateral, mandibular	No charge
D1551	Re–cement or re-bond bilateral space maintainer – maxillary	No charge
D1552	Re–cement or re-bond bilateral space maintainer – mandibular	No charge
D1553	Re–cement or re-bond unilateral space maintainer – per quadrant	No charge
D1556	Removal of fixed unilateral space maintainer – per quadrant	No charge
D1557	Removal of fixed bilateral space maintainer – maxillary	No charge
D1558	Removal of fixed bilateral space maintainer – mandibular	No charge
D1575	Distal shoe space maintainer – fixed – unilateral –– per quadrant	No charge
Restorative		
D2140	Amalgam – one surface, primary limited to once in a 12 month period	20%
D2140	Amalgam – one surface, permanent limited to once in a 36 month period	20%
D2150	Amalgam – two surfaces, primary limited to once in a 12 month period	20%
D2150	Amalgam – two surfaces, permanent limited to once in a 36 month period	20%
D2160	Amalgam – three surfaces, primary limited to once in a 12 month period	20%
D2160	Amalgam – three surfaces, permanent limited to once in a 36 month period	20%
D2161	Amalgam – four or more surfaces, primary limited to once in a 12 month period	20%
D2161	Amalgam – four or more surfaces, permanent limited to once in a 36 month period	20%
D2330	Resin–based composite – one surface, anterior, primary limited to once in a 12 month period	20%
D2330	Resin–based composite – one surface, anterior, permanent limited to once in a 36 month period	20%
D2331	Resin–based composite – two surfaces, anterior primary limited to once in a 12 month period	20%
D2331	Resin–based composite – two surfaces, anterior permanent limited to once in a 36 month period	20%
D2332	Resin–based composite – three surfaces, anterior primary limited to once in a 12 month period	20%
D2332	Resin–based composite – three surfaces, anterior permanent limited to once in a 36 month period	20%
D2335	Resin–based composite – four or more surfaces (anterior) primary limited to once in a 12 month period	20%
D2335	Resin–based composite – four or more surfaces (anterior) permanent limited to once in a 36 month period	20%
D2390	Resin–based composite crown, anterior, primary limited to once in a 12 month period	20%
D2390	Resin–based composite crown, anterior, permanent limited to once in a 36 month period	20%
D2391	Resin–based composite – one surface, posterior primary limited to once in a 12 month period	20%
D2391	Resin–based composite – one surface, posterior permanent limited to once in a 36 month period	20%
D2392	Resin–based composite – two surfaces, posterior; primary limited to once in a 12 month period	20%
D2392	Resin–based composite – two surfaces, posterior; permanent limited to once in a 36 month period	20%
D2393	Resin–based composite – three surfaces, posterior; primary limited to once in a 12 month period	20%
D2393	Resin–based composite – three surfaces, posterior; permanent limited to once in a 36 month period	20%

Code	Service	Member cost share
D2394	Resin–based composite – four or more surfaces, posterior; primary limited to once in a 12 month period	20%
D2394	Resin–based composite – four or more surfaces, posterior; permanent limited to once in a 36 month period	20%
D2710	Crown – resin–based composite (indirect) limited to once in a 5 year period	20%
D2712	Crown – ¾ resin–based composite (indirect) limited to once in a 5 year period	20%
D2721	Crown – resin with predominantly base metal limited to once in a 5 year period	20%
D2740	Crown – porcelain/ceramic limited to once in a 5 year period	20%
D2751	Crown – porcelain fused to predominantly base metal limited to once in a 5 year period	20%
D2781	Crown – ¾ cast predominantly base metal limited to once in a 5 year period	20%
D2783	Crown – ¾ porcelain/ceramic limited to once in a 5 year period	20%
D2791	Crown – full cast predominantly base metal limited to once in a 5 year period	20%
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12 month period	20%
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	20%
D2920	Recement or re-bond crown	20%
D2921	Reattachment of tooth fragment, incisal edge or cusp	20%
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	20%
D2929	Prefabricated porcelain/ceramic crown – primary tooth limited to once in a 12 month period	20%
D2930	Prefabricated stainless steel crown – primary tooth limited to once in a 12 month period	20%
D2931	Prefabricated stainless steel crown – permanent tooth limited to once in a 36 month period	20%
D2932	Prefabricated resin crown, primary limited to once in a 12 month period	20%
D2932	Prefabricated resin crown, permanent limited to once in a 36 month period	20%
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12 month period	20%
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36 month period	20%
D2940	Protective restoration limited to once per tooth in a 12 month period	20%
D2941	Interim therapeutic restoration – primary dentition	20%
D2949	Restorative foundation for an indirect restoration	20%
D2950	Core buildup, including any pins when required	20%
D2951	Pin retention – per tooth, in addition to restoration	20%
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	20%
D2953	Each additional indirectly fabricated post – same tooth	20%
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	20%
D2955	Post removal	20%
D2957	Each additional prefabricated post – same tooth	20%
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework	20%
D2976	Band stabilization – per tooth	20%
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.	20%
D2989	Excavation of a tooth resulting in the determination of non-restorability	20%
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge
D2999	Unspecified restorative procedure, by report	20%
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	50%
D3120	Pulp cap – indirect (excluding final restoration)	50%
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	50%
D3221	Pupal debridement primary and permanent teeth	50%
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	50%
D3230	Pulpal therapy (resorbable filing) – anterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%
D3240	Pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%

(continued)

Code	Service	Member cost share
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3331	Treatment of root canal obstruction; non-surgical access	50%
D3333	Internal root repair of perforation defects	50%
D3346	Retreatment of previous root canal therapy – anterior	50%
D3347	Retreatment of previous root canal therapy – premolar	50%
D3348	Retreatment of previous root canal therapy – molar	50%
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	50%
D3352	Apexification/recalcification – interim medication replacement only following D3351. Limited to once per permanent tooth	50%
D3410	Apicoectomy – anterior	50%
D3421	Apicoectomy – premolar (first root)	50%
D3425	Apicoectomy – molar (first root)	50%
D3426	Apicoectomy (each additional root)	50%
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	50%
D3429	Bone graft with periradicular surgery each additional contiguous tooth in the same surgical site	50%
D3430	Retrograde filling – per root	50%
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	50%
D3471	Surgical repair of root resorption – anterior	50%
D3472	Surgical repair of root resorption – premolar	50%
D3473	Surgical repair of root resorption – molar	50%
D3910	Surgical procedure for isolation of tooth with rubber dam	50%
D3999	Unspecified endodontic procedure, by report	50%
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months	50%
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months	50%
D4249	Clinical crown lengthening – hard tissue	50%
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth spaces per quadrant – once per quadrant every 36 months	50%
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months	50%
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	50%
D4341	Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24 months	50%
D4342	Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24 months	50%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	50%
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%
D4910	Periodontal maintenance limited to once in a calendar quarter	20%
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per member per provider; for members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	50%
D4999	Unspecified periodontal procedure, by report	50%
Prosthodontics, removable		50%
D5110	Complete denture – maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	50%
D5120	Complete denture – mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	50%
D5130	Immediate denture – maxillary	50%
D5140	Immediate denture – mandibular	50%
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%

Code	Service	Member cost share
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	50%
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	50%
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	50%
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5410	Adjust complete denture – maxillary limited to once per date of service; twice in a 12 month period	50%
D5411	Adjust complete denture – mandibular limited to once per date of service; twice in a 12 month period	50%
D5421	Adjust partial denture – maxillary limited to once per date of service; twice in a 12 month period	50%
D5422	Adjust partial denture – mandibular limited to once per date of service; twice in a 12 month period	50%
D5511	Repair broken complete denture base, mandibular	50%
D5512	Repair broken complete denture base, maxillary	50%
D5520	Replace missing or broken teeth – complete denture (each tooth) limited to a maximum of four, per arch, per date of service; twice per arch in a 12 month period	50%
D5611	Repair resin denture base, mandibular	50%
D5612	Repair resin denture base, maxillary	50%
D5621	Repair cast framework, mandibular	50%
D5622	Repair cast framework, maxillary	50%
D5630	Repair or replace broken retentive/clasping materials– per tooth – limited to a maximum of three, per date of service; twice per arch in a 12 month period	50%
D5640	Replace broken teeth – per tooth – limited to maximum of four, per arch, per date of service; twice per arch in a 12 month period	50%
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of service; once per tooth	50%
D5660	Add clasp to existing partial denture – per tooth – limited to a maximum of three, per date of service; twice per arch in a 12 month period	50%
D5730	Reline complete maxillary denture (chairside) limited to once in a 12 month period	50%
D5731	Reline complete mandibular denture (chairside) limited to once in a 12 month period	50%
D5740	Reline maxillary partial denture (chairside) limited to once in a 12 month period	50%
D5741	Reline mandibular partial denture (chairside) limited to once in a 12 month period	50%
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12 month period	50%
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12 month period	50%
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12 month period	50%
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12 month period	50%
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36 month period	50%
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	50%
D5862	Precision attachment, by report	50%
D5863	Overdenture – complete maxillary	50%
D5864	Overdenture – partial maxillary	50%
D5865	Overdenture – complete mandibular	50%
D5866	Overdenture – partial mandibular	50%
D5899	Unspecified removable prosthodontic procedure, by report	50%
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	50%
D5912	Facial moulage (complete)	50%
D5913	Nasal prosthesis	50%
D5914	Auricular prosthesis	50%
D5915	Orbital prosthesis	50%
D5916	Ocular prosthesis	50%
D5919	Facial prosthesis	50%
D5922	Nasal septal prosthesis	50%

(continued)

Code	Service	Member cost share
D5923	Ocular prosthesis, interim	50%
D5924	Cranial prosthesis	50%
D5925	Facial augmentation implant prosthesis	50%
D5926	Nasal prosthesis, replacement	50%
D5927	Auricular prosthesis, replacement	50%
D5928	Orbital prosthesis, replacement	50%
D5929	Facial prosthesis, replacement	50%
D5931	Obturator prosthesis, surgical	50%
D5932	Obturator prosthesis, definitive	50%
D5933	Obturator prosthesis, modification limited to twice in a 12 month period	50%
D5934	Mandibular resection prosthesis with guide flange	50%
D5935	Mandibular resection prosthesis without guide flange	50%
D5936	Obturator prosthesis, interim	50%
D5937	Trismus appliance (not for TMD treatment)	50%
D5951	Feeding aid	50%
D5952	Speech aid prosthesis, pediatric	50%
D5953	Speech aid prosthesis, adult	50%
D5954	Palatal augmentation prosthesis	50%
D5955	Palatal lift prosthesis, definitive	50%
D5958	Palatal lift prosthesis, interim	50%
D5959	Palatal lift prosthesis, modification limited to twice in a 12 month period	50%
D5960	Speech aid prosthesis, modification limited to twice in a 12 month period	50%
D5982	Surgical stent	50%
D5983	Radiation carrier	50%
D5984	Radiation shield	50%
D5985	Radiation cone locator	50%
D5986	Fluoride gel carrier	50%
D5987	Commissure splint	50%
D5988	Surgical splint	50%
D5991	Vesiculobullous disease medicament carrier	50%
D5999	Unspecified maxillofacial prosthesis, by report	50%
Implant Services		50%
D6010	Surgical placement of implant body: endosteal implant	50%
D6011	Surgical access to an implant body (second stage implant surgery)	50%
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	50%
D6013	Surgical placement of mini implant	50%
D6040	Surgical placement: eposteal implant	50%
D6050	Surgical placement: transosteal implant	50%
D6055	Connecting bar – implant supported or abutment supported	50%
D6056	Prefabricated abutment – includes modification and placement	50%
D6057	Custom fabricated abutment – includes placement	50%
D6058	Abutment supported porcelain/ceramic crown	50%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	50%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	50%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	50%
D6062	Abutment supported cast metal crown (high noble metal)	50%
D6063	Abutment supported cast metal crown (predominantly base metal)	50%
D6064	Abutment supported cast metal crown (noble metal)	50%
D6065	Implant supported porcelain/ceramic crown	50%
D6066	Implant supported crown (porcelain fused to high noble alloys)	50%
D6067	Implant supported crown (high noble alloys)	50%
D6068	Abutment supported retainer for porcelain/ceramic FPD	50%
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	50%

Code	Service	Member cost share
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	50%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	50%
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	50%
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	50%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	50%
D6075	Implant supported retainer for ceramic FPD	50%
D6076	Implant supported retainer FPD (porcelain fused to high noble alloys)	50%
D6077	Implant supported retainer for metal FPD (high noble alloys)	50%
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	50%
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	50%
D6082	Implant supported crown – porcelain fused to predominantly bass alloys	50%
D6083	Implant supported crown – porcelain fused to noble alloys	50%
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	50%
D6085	Interim implant crown	50%
D6086	Implant supported crown – predominantly base alloys	50%
D6087	Implant supported crown – noble alloys	50%
D6088	Implant supported crown – titanium and titanium alloys	50%
D6089	Accessing and retorquing loose implant screw – per screw	50%
D6090	Repair implant supported prosthesis, by report	50%
D6091	Replacement of replaceable part of semi–precision or precision attachment of implant/abutment supported prosthesis, per attachment	50%
D6092	Recement implant/abutment supported crown	50%
D6093	Recement implant/abutment supported fixed partial denture	50%
D6094	Abutment supported crown – titanium and titanium alloys	50%
D6095	Repair implant abutment, by report	50%
D6096	Removal of broken implant retaining screw	50%
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	50%
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	50%
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	50%
D6100	Surgical removal of implant body	50%
D6105	Removal of implant body not requiring bone removal or flap elevation	50%
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	50%
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	50%
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	50%
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	50%
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	50%
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	50%
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	50%
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	50%
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	50%
D6119	Implant/abutment support interim fixed denture for edentulous arch - maxillary	50%
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	50%
D6121	Implant supported retainer for metal FPD – predominantly base alloys	50%
D6122	Implant supported retainer for metal FPD – noble alloys	50%
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	50%
D6190	Radiographic/Surgical implant index, by report	50%
D6191	Semi–precision abutment – placement	50%
D6192	Semi–precision attachment – placement	50%
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	50%
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	50%

(continued)

Code	Service	Member cost share
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	50%
D6198	Remove interim implant component	50%
D6199	Unspecified implant procedure, by report	50%
Prosthodontics, fixed		50%
D6211	Pontic – cast predominantly base metal limited to once in a 5 year period	50%
D6241	Pontic – porcelain fused to predominantly base metal limited to once in a 5 year period	50%
D6245	Pontic – porcelain/ceramic limited to once in a 5 year period	50%
D6251	Pontic – resin with predominantly base metal limited to once in a 5 year period	50%
D6721	Retainer crown – resin predominantly base metal – denture limited to once in a 5 year period	50%
D6740	Retainer crown – porcelain/ceramic limited to once in a 5 year period	50%
D6751	Retainer crown – porcelain fused to predominantly base metal limited to once in a 5 year period	50%
D6781	Retainer crown – ¾ cast predominantly base metal limited to once in a 5 year period	50%
D6783	Retainer crown – ¾ porcelain/ceramic limited to once in a 5 year period	50%
D6784	Retainer crown – ¾ titanium and titanium alloys	50%
D6791	Retainer crown – full cast predominantly base metal limited to once in a 5 year period	50%
D6930	Recement or re-bond fixed partial denture	50%
D6980	Fixed partial denture repair necessitated by restorative material failure	50%
D6999	Unspecified fixed prosthodontic procedure, by report	50%
Oral Maxillofacial Prosthetics		50%
D7111	Extraction, coronal remnants – primary tooth	50%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	50%
D7220	Removal of impacted tooth – soft tissue	50%
D7230	Removal of impacted tooth – partially bony	50%
D7240	Removal of impacted tooth – completely bony	50%
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	50%
D7250	Removal of residual tooth roots (cutting procedure)	50%
D7260	Oroantral fistula closure	50%
D7261	Primary closure of a sinus perforation	50%
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	50%
D7280	Exposure of an unerupted tooth	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%
D7284	Excisional biopsy of minor salivary glands	50%
D7285	Incisional biopsy of oral tissue – hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	50%
D7286	Incisional biopsy of oral tissue – soft limited to removal of the specimen only; up to a maximum of 3 per date of service	50%
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	50%
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	50%
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140–D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	50%
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	50%
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	50%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	50%
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) limited to once in a 5 year period per arch	50%
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	50%
D7410	Excision of benign lesion up 1.25 cm	50%
D7411	Excision of benign lesion greater than 1.25 cm	50%

Code	Service	Member cost share
D7412	Excision of benign lesion, complicated	50%
D7413	Excision of malignant lesion up to 1.25 cm	50%
D7414	Excision of malignant lesion greater than 1.25 cm	50%
D7415	Excision of malignant lesion, complicated	50%
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	50%
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	50%
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	50%
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	50%
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	50%
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	50%
D7465	Destruction of lesion(s) by physical or chemical method, by report	50%
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	50%
D7472	Removal of torus palatinus limited to once in a patient's lifetime	50%
D7473	Removal of torus mandibularis limited to once per quadrant	50%
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	50%
D7490	Radical resection of maxilla or mandible	50%
D7509	Marsupialization of odontogenic cyst	50%
D7510	Incision and drainage of abscess – intraoral soft tissue limited to once per quadrant, same date of service	50%
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	50%
D7520	Incision and drainage of abscess – extraoral soft tissue	50%
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	50%
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	50%
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	50%
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone limited to once per quadrant per date of service	50%
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%
D7610	Maxilla – open reduction (teeth immobilized, if present)	50%
D7620	Maxilla – closed reduction (teeth immobilized, if present)	50%
D7630	Mandible – open reduction (teeth immobilized, if present)	50%
D7640	Mandible – closed reduction (teeth immobilized, if present)	50%
D7650	Malar and/or zygomatic arch – open reduction	50%
D7660	Malar and/or zygomatic arch – closed reduction	50%
D7670	Alveolus – closed reduction, may include stabilization of teeth	50%
D7671	Alveolus – open reduction, may include stabilization of teeth	50%
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	50%
D7710	Maxilla – open reduction	50%
D7720	Maxilla – closed reduction	50%
D7730	Mandible – open reduction	50%
D7740	Mandible – closed reduction	50%
D7750	Malar and/or zygomatic arch – open reduction	50%
D7760	Malar and/or zygomatic arch – closed reduction	50%
D7770	Alveolus – open reduction stabilization of teeth	50%
D7771	Alveolus, closed reduction stabilization of teeth	50%
D7780	Facial bones – complicated reduction with fixation and multiple approaches	50%
D7810	Open reduction of dislocation	50%
D7820	Closed reduction of dislocation	50%
D7830	Manipulation under anesthesia	50%
D7840	Condylectomy	50%
D7850	Surgical discectomy, with/without implant	50%
D7852	Disc repair	50%
D7854	Synovectomy	50%
D7856	Myotomy	50%

(continued)

Code	Service	Member cost share
D7858	Joint reconstruction	50%
D7860	Arthrotomy	50%
D7865	Arthroplasty	50%
D7870	Arthrocentesis	50%
D7871	Non–arthroscopic lysis and lavage	50%
D7872	Arthroscopy – diagnosis, with or without biopsy	50%
D7873	Arthroscopy – lavage and lysis of adhesions	50%
D7874	Arthroscopy – disc repositioning and stabilization	50%
D7875	Arthroscopy – synovectomy	50%
D7876	Arthroscopy – discectomy	50%
D7877	Arthroscopy – debridement	50%
D7880	Occlusal orthotic device, by report	50%
D7881	Occlusal orthotic device adjustment	50%
D7899	Unspecified TMD therapy, by report	50%
D7910	Suture of recent small wounds up to 5 cm	50%
D7911	Complicated suture – up to 5 cm	50%
D7912	Complicated suture – greater than 5 cm	50%
D7920	Skin graft (identify defect covered, location and type of graft)	50%
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	50%
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	50%
D7940	Osteoplasty – for orthognathic deformities	50%
D7941	Osteotomy – mandibular rami	50%
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	50%
D7944	Osteotomy – segmented or subapical	50%
D7945	Osteotomy – body of mandible	50%
D7946	LeFort I (maxilla – total)	50%
D7947	LeFort I (maxilla – segmented)	50%
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	50%
D7949	LeFort II or LeFort III – with bone graft	50%
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report	50%
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	50%
D7952	Sinus augmentation via a vertical approach	50%
D7955	Repair of maxillofacial soft and/or hard tissue defect	50%
D7961	Buccal/labial frenectomy (frenulectomy)	50%
D7962	Lingual frenectomy (frenulectomy)	50%
D7963	Frenuloplasty limited to once per arch per date of service	50%
D7970	Excision of hyperplastic tissue – per arch limited to once per arch per date of service	50%
D7971	Excision of pericoronal gingiva	50%
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	50%
D7979	Non-surgical sialolithotomy	50%
D7980	Surgical sialolithotomy	50%
D7981	Excision of salivary gland, by report	50%
D7982	Sialodochoplasty	50%
D7983	Closure of salivary fistula	50%
D7990	Emergency tracheotomy	50%
D7991	Coronoidectomy	50%
D7995	Synthetic graft – mandible or facial bones, by report	50%
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	50%
D7999	Unspecified oral surgery procedure, by report	50%

Code	Service	Member cost share
Orthodontics		50%
	Medically necessary banded case (The copayment applies to a member's course of treatment as long as that member remains enrolled in this plan.)	50%
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
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	
D8696	Repair of orthodontic appliance – maxillary	
D8697	Repair of orthodontic appliance – mandibular	
D8698	Recement or re-bond fixed retainer – maxillary	
D8699	Recement or re-bond fixed retainer – mandibular	
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	
D8704	Replacement of lost or broken retainer – mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative treatment of dental pain – per visit	50%
D9120	Fixed partial denture sectioning	50%
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	50%
D9211	Regional block anesthesia	50%
D9212	Trigeminal division block anesthesia	50%
D9215	Local anesthesia in conjunction with operative or surgical procedures	50%
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	50%
D9222	Deep sedation/general anesthesia – first 15 minutes	50%
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	50%
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	50%
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	50%
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	50%
D9248	Non–intravenous conscious sedation	50%
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	50%
D9311	Consultation with a medical health professional	No charge
D9410	House/Extended care facility call	50%
D9420	Hospital or ambulatory surgical center call	50%
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	50%
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	50%
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	50%
D9612	Therapeutic parenteral drug, two or more administrations, different medications	50%
D9910	Application of desensitizing medicament limited to once in a 12 month period; permanent teeth only	50%
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	50%
D9950	Occlusion analysis – mounted case limited to once in a 12 month period	50%
D9951	Occlusal adjustment – limited. Limited to once in a 12 month period per quadrant	50%
D9952	Occlusal adjustment – complete. Limited to once in a 12 month period following occlusion analysis– mounted case (D9950)	50%
D9995	Teledentistry – synchronous; real–time encounter. Limited to twice in a 12 month period.	No charge
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12 month period.	No charge
D9997	Dental case management – patients with special health care needs	No charge
D9999	Unspecified adjunctive procedure, by report	No charge

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

Pediatric dental care program exclusions and limitations

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

Important: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide 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 member services at **866-249-2382** or your broker. To fully understand your coverage, you may wish to carefully review the Health Net Individual & Family Plan *Contract and Evidence of Coverages (EOC)*.

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

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental
2. Any procedure that in the professional opinion of the attending dentist: (a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or (b) is inconsistent with generally accepted standards for dentistry.
3. Temporomandibular joint treatment (aka "TMJ").
4. Elective dentistry and cosmetic dentistry.
5. Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery, and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
6. Treatment of malignancies, cysts, neoplasms, or congenital malformations.
7. Prescription medications.
8. Hospital charges of any kind.
9. Loss or theft of full or partial dentures.
10. Any procedure of implantation.
11. Any experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process. See the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" in the Health Net Individual & Family *Plan Contract and EOC*.
12. Services that cannot be performed because of the physical or behavioral limitations of the patient.
13. Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
14. Any procedure performed for the purpose of correcting contour, contact or occlusion.
15. Any procedure that is not specifically listed as a covered service in the Health Net Individual & Family *Plan Contract and EOC*.
16. Services that were provided without cost to the member by state government or an agency thereof, or any municipality, county, or other subdivisions.
17. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member becomes eligible for such services.
18. Dispensing of drugs not normally supplied in a dental office.
19. The cost of precious metals used in any form of dental benefits.
20. Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by their panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or their plan provider is a pedodontist/pediatric dentist.
21. Dental services that are received in an emergency care setting
22. Services from a non-network provider.

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 Contract and Evidence of Coverage*.

- 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 has been obtained.
- Amounts charged by out-of-network providers for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as described in the Health Net Individual & Family *Plan Contract and Evidence of Coverages (EOC)*.
- Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.
- 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.
- Any charges incurred by a baby beyond 31 days (including the date of birth) are excluded unless the baby is enrolled under this health plan within 31 days (including the date of birth). If you do not enroll your newborn child within 31 days (including the date of birth), your child will be eligible to enroll under a special enrollment period within 60 days of birth.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Coverage for fertility preservation does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates).
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.[4]
- 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.
- 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 vision 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.
- This health plan does not cover health care services, including supplies and prescription drugs, to a surrogate, including a member and/or family member acting as a surrogate or utilizing the services of a surrogate who may or may not be a member and/or family member, and any child born as a result of a surrogacy arrangement. This exclusion applies to all health care services, supplies and prescription drugs rendered to a surrogate. See the plan's *Plan Contract and EOC* for additional information:
- 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 physician 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; (g) orthotics and corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications); and (h) other orthotics, including corrective, not mentioned above, unless medically necessary and custom made for the member. Corrective footwear must also be permanently attached to an orthotic device meeting coverage requirements under this health plan.
- Personal comfort items.
- Disposable supplies for home use, except certain disposable ostomy or urological supplies. See the *Plan Contract and EOC* for additional information.
- 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).
- 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 contraception approved by the FDA).
- Routine foot care, unless prescribed for the treatment of diabetes or peripheral vascular disease.

(continued)

[4]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.

- Services or supplies to diagnose, evaluate or treat infertility are not covered. Excluded procedures include, but are not limited to: conception by medical procedures, such as artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services; and collection, storage or purchase of sperm or ova.
- Except for services related to behavioral health treatment which are shown as covered in the Individual & Family *Plan Contract and EOC*, 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 their license, to treat physical conditions and mental health and substance use disorders, 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 their license, to treat physical conditions and mental health and substance use disorders, 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 health and substance use disorders: (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 substance use disorder conditions only if amenable to psychotherapeutic, psychiatric, or substance use disorder treatment. This provision does not impair coverage for the medically necessary treatment of any mental health and substance use disorder identified as a mental health and substance use disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision as amended in the most recently issued edition or for medically necessary treatment 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 health and substance use disorder 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, as amended in the most recently issued edition.
- Services that do not meet national standards for professional medical health or mental health and substance use disorder practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, 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. Hypnotherapy services are covered as part of a comprehensive evidence-based mental health treatment plan and provided by a licensed mental health provider with a medical hypnotherapy certification.
- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and mental health and substance use disorders.
- Psychological testing except as conducted by participating mental health professionals who are licensed and acting within the scope of their license 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.
- Medical and mental health and substance use disorder services as a condition of parole or probation, and court-ordered treatment and testing are limited to medically necessary covered services.

  Exception: The plan will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for a member when required or recommended for the member pursuant to a Community Assistance, Recovery, and Empowerment (CARE) agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. Services are provided to the member with no cost-share or prior authorization, except for prescription drugs. Prescription drugs are subject to the cost share shown in the "Schedule of Benefits" in the *Plan Contract and EOC* and may require prior authorization.
- Annual physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. An annual 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.
- Telehealth consultations through the select telehealth services provider do not cover: Specialist services; and Prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse.
- 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 or your Physician Group.

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

PRINCIPAL BENEFITS AND COVERAGES FOR DENTAL CARE WITH AMBETTER PPO PLUS PLANS

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

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

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 any annual maximum dollar benefit limitations. Simply present your Health Net dental member ID card to the participating primary dentist you selected. It's that simple!

Copayments for dental services benefits under the Ambetter PPO Plus plans:

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

Dental Plan Schedule of Benefits

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

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide 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.

Medically Necessary Dental Services

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

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

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

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

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

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

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

PRINCIPAL BENEFITS AND COVERAGES FOR VISION PROVIDED WITH AMBETTER PPO PLUS PLANS

Provided by Health Net of California. Health Net contracts with Centene Vision Services to provide vision services benefits. This benefit is included only with Ambetter PPO Plus plans.

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

Copayments for vision services benefits under the Ambetter PPO Plus plans:

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

Benefits and coverage matrix for vision care provided Ambetter PPO Plus plans

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

Summary of vision benefits

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

*Contact Lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

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

Vision examination

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

Frames

If the exam indicates the necessity of eyeglasses, this vision plan will cover a frame once every 12 months up to a maximum of $80 retail frame allowance plus 20 percent off balance over allowance.

If the member selects frames that are more expensive than this allowance, the member will be charged 80% of the difference between the allowance and the retail cost of the more expensive frames.

Eyeglass Lenses

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

Medically necessary contact lenses

Coverage of medically necessary contact lenses is subject to medical necessity, 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 Ambetter PPO Plus plans

The following vision services and expenses are not covered under the Ambetter PPO Plus plans:

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

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

Nondiscrimination Notice

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

HEALTH NET:

- 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./Health Net Life Insurance Company 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.

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

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

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

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

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

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

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

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យ លោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ ប្រសិនបើលោកអ្នកមានប័ណ្ណសម្គាល់ខ្លួន សូមហៅទូរស័ព្ទទៅកាន់ លេខរបស់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជន។ អ្នកដាក់ពាក្យសុំគម្រោងជាក្រុមដែលជាបុគ្គលិក សូមហៅទូរស័ព្ទទៅ កាន់មជ្ឈមណ្ឌលទំនាក់ទំនងរបស់ Health Net តាមរយៈលេខ 1-800-522-0088 (TTY: 711)។ អ្នកដាក់ពាក្យសុំ គម្រោងជាលក្ខណៈបុគ្គល 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 ákódoolníłh. Ákót’éego shíká a’doowoł nínízingo Customer Contact Center hoolyéhíjį’ hodíílnih ninaaltsoos nanitingo bee néého’dolzinígíí hodoonihjį’ bikáá’. Naaltsoos nehiltsóosgo naanish bá dahikahígíí éí kojį’ hodíílnih Health Net’s Commercial Contact Center 1-800-522-0088 (TTY: 711). T’áá hó dóó ha’áłchíní (IFP) báhígíí éí kojį’ hojilnih 1-877-609-8711 (TTY: 711).

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

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

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

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

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

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

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu 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).

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Contact Us

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877-339-8596 (Korean)
877-891-9053 (Mandarin)
800-331-1777 (Spanish)
877-891-9051 (Tagalog)
877-339-8621 (Vietnamese)

Telecommunications device for the Hearing and Speech Impaired:

800-995-0852

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