Health Net of California, Inc. (Health Net)

Individual & Family Plans

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Individual & Family Exchange Ambetter HMO Plans

THROUGH COVERED CALIFORNIA™

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This document is only a summary of your health coverage. You have the right to view the plan's *Plan Contract and Evidence of Coverage (EOC)* prior to enrollment. To obtain a copy of this document, contact your authorized Health Net agent or your Health Net sales representative at **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, gender identity, sexual orientation, age or disability, and are not subject to any pre-existing condition or exclusion period.

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

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

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

Health Net Ambetter HMO Network

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

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

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

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

Health Net Ambetter Pharmacy Network

Not all pharmacies who contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency, only those pharmacies specifically identified as participating in the Ambetter Pharmacy Network may provide the prescription drugs benefit under this plan. For a list of pharmacies participating in the Ambetter Pharmacy Network, call our Health Net Customer Contact Center or visit our website at www.myhealthnetca.com.

Pharmacies that are not in the Ambetter Pharmacy Network are considered nonparticipating pharmacies under this plan.

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

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

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

Obtaining covered services under the Health Net Ambetter HMO Network plan

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

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

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

Health Net Individual & Family Coverage for You and Your Family

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

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

Is an HMO right for you?

With our Ambetter HMO plans, you are required to choose a PCP. Your PCP will provide and coordinate your medical care. You have the right to designate any PCP who participates in our Health Net Ambetter HMO Network, has an office close enough to your residence to allow reasonable access to medical care and who is available to accept you or your family members, subject to the requirement of the physician group. For children,a pediatrician may be designated as the PCP. Until you make your PCP designation, Health Net designates one for you. Information about how to select a PCP and a listing of the participating PCPs in the Health Net Ambetter HMO 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.

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

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

You do not need prior authorization from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical, gynecological, or reproductive and sexual health care services from an in-network health care professional who specializes in obstetrics, gynecology, or reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

A listing of participating health care professionals who specialize in obstetrics, gynecology, or reproductive and sexual health is available on the Health Net website at **www.myhealthnetca.com.** You can also call **877-609-8711** to request provider information or contact your Health Net authorized broker. Refer to the "Mental Health and Substance Use Disorder Services" section in this document for mental health and substance use disorders.

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

Calendar year deductible

For some HMO plans, a calendar year deductible is required for certain services and 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.

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

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

Timely Access to Care

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

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

For further information, please refer to the Individual & Family Plan HMO Exchange *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.

Health Net of California Inc. (Health Net)

California Individual & Family Plans Available through Covered California

Plan Overview – Platinum 90 Ambetter HMO

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

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$4,500 single / $9,000 family
Professional services Office visit copay[1]	$15
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$30
Other practitioner office visit (including medically necessary acupuncture)[3]	$15
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$30
Laboratory tests	$15
Imaging (CT, PET scans, MRIs)	$75
Rehabilitation and habilitation therapy	$15
Outpatient services Outpatient surgery	$75 facility / $20 physician
Hospital services Inpatient hospital stay (includes maternity)	Facility: $225/day (up to 5 days); Physician: $0
Skilled nursing facility (maximum of 100 days per calendar year for each member)	$125/day (up to 5 days)[5]
Emergency services Emergency room services (copays waived if admitted)	$150 facility / $0 physician
Urgent care	$15
Ambulance services (ground and air)	$150
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: $225/day (up to 5 days); Physician: $0
Mental/Behavioral health/substance use disorder (outpatient)	$15 office visit / $0 other than office visit
Home health care services (100 visits per calendar year)	$20
Other services Durable medical equipment	10%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$7
Tier 2 (non-preferred generics and preferred brand)	$16
Tier 3 (non-preferred brand)	$25
Tier 4 (Specialty drugs)[10]	10% up to $250/script

Benefit description	Member(s) responsibility
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

NOTE: In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are essential health benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for essential health benefits when items or services are provided by any participating provider.

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

[2] 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.

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

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

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

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

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

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

[9] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

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

(1/25)

Health Net of California Inc. (Health Net)

California Individual & Family Plans Available through Covered California

Plan Overview – Gold 80 Ambetter HMO

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

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$8,700 single / $17,400 family
Professional services Office visit copay[1]	$35
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$65
Other practitioner office visit (including medically necessary acupuncture)[3]	$35
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$75
Laboratory tests	$40
Imaging (CT, PET scans, MRIs)	$75
Rehabilitation and habilitation therapy	$35
Outpatient services Outpatient surgery	Facility: $130; Physician: $60
Hospital services Inpatient hospital stay (includes maternity)	Facility: $350/day (up to 5 days); Physician: $0
Skilled nursing care facility (maximum of 100 days per calendar year for each member)	$150/day (up to 5 days)[5]
Emergency services Emergency room services (copays waived if admitted)	Facility: $330; Physician: $0
Urgent care	$35
Ambulance services (ground and air)	$250
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: $350/day (up to 5 days); Physician: $0
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $35 / Other than office visit: $0
Home health care services (100 visits per calendar year)	$30
Other services Durable medical equipment	20%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$15
Tier 2 (non-preferred generics and preferred brand)	$60
Tier 3 (non-preferred brand)	$85
Tier 4 (Specialty drugs)[10]	20% up to $250/script

Benefit description	Member(s) responsibility
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

NOTE: In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are essential health benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for essential health benefits when items or services are provided by any participating provider.

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

[2] 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.

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

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

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

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

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

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

[9] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

[12] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with 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 through Covered California

Plan Overview – Silver 70 Ambetter HMO

The Silver 70 Ambetter HMO health plan utilizes the **Ambetter HMO** provider network for covered benefits and services. **Ambetter HMO** is available through Covered California in Imperial, Los Angeles, Orange and San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible[1]	$5,400 single / $10,800 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$8,700 single / $17,400 family
Professional services Office visit copay[2]	$50 (deductible waived)
Telehealth consultation through the select telehealth services provider[3]	$0 (deductible waived)
Specialist visit[2]	$90 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture)[4]	$50 (deductible waived)
Preventive care services[2,5]	$0 (deductible waived)
X-ray and diagnostic imaging	$95 (deductible waived)
Laboratory tests	$50 (deductible waived)
Imaging (CT, PET scans, MRIs)	$325 (deductible waived)
Rehabilitation and habilitation therapy	$50 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	30% (deductible waived)
Hospital services Inpatient hospital stay (includes maternity)	Facility: 30%; Physician: 30% (deductible waived)[6]
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30%
Emergency services Emergency room services (copay waived if admitted)	Facility: $400 (deductible waived); Physician: $0 (deductible waived)
Urgent care	$50 (deductible waived)
Ambulance services (ground and air)	$250 (deductible waived)
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 30%; Physician: 30% (deductible waived)[6]
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $50 (deductible waived) Other than office visit: 30% up to $50 (deductible waived)
Home health care services (100 visits per calendar year)	$45 (deductible waived)
Other services Durable medical equipment	20% (deductible waived)
Hospice service	$0 (deductible waived)
Prescription drug coverage[7,8,9,10,11] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	$50 single / $100 family
Tier 1 (most generics and low-cost preferred brand)	$18 (Rx deductible waived)
Tier 2 (non-preferred generics and preferred brand)	$60 (Rx deductible applies)
Tier 3 (non-preferred brand)	$90 (Rx deductible applies)

Benefit description	Member(s) responsibility
Tier 4 (Specialty drugs)[12]	20% up to $250/script after Rx deductible
Pediatric dental[13] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[14] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0 (deductible waived)

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

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

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

[3] 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.

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

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

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

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

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

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

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

[11] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

[14] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with 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 through Covered California

Plan Overview – Silver 94 Ambetter HMO

The Silver 94 Ambetter HMO health plan utilizes the **Ambetter HMO** provider network for covered benefits and services. **Ambetter HMO** is available through Covered California in Imperial, Los Angeles, Orange and San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

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Benefit description	Member(s) responsibility
Unlimited lifetime maximum.	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$1,150 single / $2,300 family
Professional services Office visit copay[1]	$5
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$8
Other practitioner office visit (including medically necessary acupuncture)[3]	$5
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$8
Laboratory tests	$8
Imaging (CT, PET scans, MRIs)	$50
Rehabilitation and habilitation therapy	$5
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	10%
Hospital services Inpatient hospital stay (includes maternity)	Facility: 10%; Physician: 10%[5]
Skilled nursing facility (maximum of 100 days per calendar year for each member)	10%
Emergency services Emergency room services (copay waived if admitted)	Facility: $50; Physician: $0
Urgent care	$5
Ambulance services (ground and air)	$30
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 10%; Physician: 10%[5]
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $5 Other than office visit: 10% up to $5
Home health care services (100 visits per calendar year)	$3
Other services Durable medical equipment	10%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$3
Tier 2 (non-preferred generics and preferred brand)	$10
Tier 3 (non-preferred brand)	$15
Tier 4 (Specialty drugs)[10]	10% up to $150/script

Benefit description	Member(s) responsibility
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

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

[2] 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.

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

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

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

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

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

[9] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

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(1/25)

Health Net of California Inc. (Health Net)

California Individual & Family Plans Available through Covered California

Plan Overview – Silver 87 Ambetter HMO

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Benefit description	Member(s) responsibility
Unlimited lifetime maximum.	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$3,000 single / $6,000 family
Professional services Office visit copay[1]	$15
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$25
Other practitioner office visit (including medically necessary acupuncture)[3]	$15
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$40
Laboratory tests	$20
Imaging (CT, PET scans, MRIs)	$100
Rehabilitation and habilitation therapy	$15
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	20%
Hospital services Inpatient hospital stay (includes maternity)	Facility: 20%; Physician: 20% [5]
Skilled nursing facility (maximum of 100 days per calendar year for each member)	20%
Emergency services Emergency room services (copay waived if admitted)	Facility: $150; Physician: $0
Urgent care	$15
Ambulance services (ground and air)	$75
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 20%; Physician: 20%[5]
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $15 Other than office visit: 20% up to $15
Home health care services (100 visits per calendar year)	$15
Other services Durable medical equipment	15%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy) Tier 1 (most generics and low-cost preferred brand)	$5
Tier 2 (non-preferred generics and preferred brand)	$25
Tier 3 (non-preferred brand)	$45
Tier 4 (Specialty drugs)[10]	15% up to $150/script

Benefit description	Member(s) responsibility
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

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

[2] 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.

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

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

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

[8] Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. Up to a 12-consecutive calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order. 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.

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

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Plan Overview – Silver 73 Ambetter HMO

The Silver 73 Ambetter HMO health plan utilizes the **Ambetter HMO** provider network for covered benefits and services. **Ambetter HMO** is available through Covered California in Imperial, Los Angeles, Orange and San Diego counties, and parts of Kern, Riverside and San Bernardino counties.

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum.	
Plan maximums Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$6,100 single / $12,200 family
Professional services Office visit copay[1]	$35
Telehealth consultation through the select telehealth services provider[2]	$0
Specialist visit[1]	$85
Other practitioner office visit (including medically necessary acupuncture)[3]	$35
Preventive care services[1,4]	$0
X-ray and diagnostic imaging	$95
Laboratory tests	$50
Imaging (CT, PET scans, MRIs)	$325
Rehabilitation and habilitation services	$35
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	30%
Hospital services Inpatient hospital stay (includes maternity)	Facility: 30%; Physician: 30% [5]
Skilled nursing facility (maximum of 100 days per calendar year for each member)	30%
Emergency services Emergency room services (copayment waived if admitted)	$350 facility / $0 physician
Urgent care	$35
Ambulance services (ground and air)	$250
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	Facility: 30%; Physician: 30% [5]
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $35 Other than office visit: 30% up to $35
Home health care services (100 visits per calendar year)	$40
Other services Durable medical equipment	20%
Hospice service	$0
Prescription drug coverage[6,7,8,9] (up to a 30-day supply obtained through a participating pharmacy)	
Tier 1 (most generics and low-cost preferred brand)	$15
Tier 2 (non-preferred generics and preferred brand)	$55
Tier 3 (non-preferred brand)	$85
Tier 4 (Specialty drugs)[10]	20% up to $250/script

Benefit description	Member(s) responsibility
Pediatric dental[11] Diagnostic and preventive services	$0
Pediatric vision[12] Routine eye exam	$0
Glasses (limitations apply)	1 pair per year – $0

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

NOTE: The Silver 73 Ambetter HMO Plan benefits are applicable for the Silver 70 Ambetter HMO AI-AN Plan. The following applies to the Silver 70 Ambetter HMO AI-AN Plan: In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are essential health benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost-sharing plan variation (because your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost-sharing obligation for essential health benefits when items or services are provided by any participating provider.

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

[2] 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.

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

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

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

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

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

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

[9] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

[12] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with 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 through Covered California

Plan Overview – Bronze 60 Ambetter HMO

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

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible[1]	$5,800 single / $11,600 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$8,850 single / $17,700 family
Professional services Office visit copay[2]	$60 (deductible waived)
Telehealth consultation through the select telehealth services provider[4]	$0 (deductible waived)
Specialist visit[2]	Visits 1–3: $95 (deductible waived)[3] / Visits 4+: $95 (deductible applies)
Other practitioner office visit (including medically necessary acupuncture)[5]	$60 (deductible waived)
Preventive care services[2,6]	$0 (deductible waived)
X-ray and diagnostic imaging	40%
Laboratory tests	$40 (deductible waived)
Imaging (CT, PET scans, MRIs)	40%
Rehabilitation and habilitation services	$60 (deductible waived)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	40%
Hospital services Inpatient hospital stay (includes maternity)	40%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	40%
Emergency services Emergency room services (copayment waived if admitted)	Facility: 40%; Physician: $0 (deductible waived)
Urgent care	$60 (deductible waived)
Ambulance services (ground and air)	40%
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	40%
Mental/Behavioral health/substance use disorder (outpatient)	Office visit: $60 (deductible waived) Other than office visit: $0 (deductible waived)
Home health care services (100 visits per calendar year)	40%
Other services Durable medical equipment	40%
Hospice service	$0 (deductible waived)
Prescription drug coverage[7,8,9,10] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	$450 single / $900 family
Tier 1 (most generics and low-cost preferred brand)	$19 (Rx deductible waived)
Tier 2 (non-preferred generics and preferred brand)	40% up to $500/script (after Rx deductible)
Tier 3 (non-preferred brand)	40% up to $500/script (after Rx deductible)
Tier 4 (Specialty drugs)[11]	40% up to $500/script (after Rx deductible)

Benefit description	Member(s) responsibility
Pediatric dental[12] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[13] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0 (deductible waived)

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

NOTE: In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are essential health benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for essential health benefits when items or services are provided by any participating provider.

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

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

[3] The calendar year deductible applies after the first 3 non-preventive specialist visits.

[4] 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.

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

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

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

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

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

[10] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

[13] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with 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 through Covered California

Plan Overview – Minimum Coverage Ambetter HMO

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

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

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

Benefit description	Member(s) responsibility
Unlimited lifetime maximum. Benefits are subject to a deductible unless noted.	
Plan maximums Calendar year deductible (also applies to prescription drugs)[1]	$9,200 single / $18,400 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	$9,200 single / $18,400 family
Professional services Office visit copay[2]	Visits 1–3: 0% (deductible waived)[3] / Visits 4+: 0% (deductible applies)
Telehealth consultation through the select telehealth services provider[4]	Visits 1–3: 0% (deductible waived)[3] / Visits 4+: 0% (deductible applies)
Specialist visit[2]	0%
Other practitioner office visit (including medically necessary acupuncture)[5]	Visits 1–3: 0% (deductible waived)[3] / Visits 4+: 0% (deductible applies)
Preventive care services[2,6]	$0 (deductible waived)
X-ray and diagnostic imaging	0%
Laboratory tests	0%
Imaging (CT, PET scans, MRIs)	0%
Rehabilitation and habilitation services	0%
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	0%
Hospital services Inpatient hospital stay (includes maternity)	0%
Skilled nursing facility (maximum of 100 days per calendar year for each member)	0%
Emergency services Emergency room services (copayment waived if admitted)	Facility: 0%; Physician: 0%
Urgent care	Visits 1–3: 0% (deductible waived)[3] / Visits 4+: 0% (deductible applies)
Ambulance services (ground and air)	0%
Mental/Behavioral health/substance use disorder services Mental/Behavioral health/substance use disorder (inpatient)	0%
Mental/Behavioral health/substance use disorder (outpatient)	Office visits 1–3: 0% (deductible waived)[3] Office visits 4+: 0% (deductible applies) / Other than office visit: 0% (deductible applies)
Home health care services (100 visits per calendar year)	0%
Other services Durable medical equipment	0%
Hospice service	0%
Prescription drug coverage[7,8,9,10] (up to a 30-day supply obtained through a participating pharmacy) Prescription drug calendar year deductible	Integrated with medical deductible
Tier 1 (most generics and low-cost preferred brand)	0%
Tier 2 (non-preferred generics and preferred brand)	0%
Tier 3 (non-preferred brand)	0%

Benefit description	Member(s) responsibility
Tier 4 (Specialty drugs)[11]	0%
Pediatric dental[12] Diagnostic and preventive services	$0 (deductible waived)
Pediatric vision[13] Routine eye exam	$0 (deductible waived)
Glasses (limitations apply)	1 pair per year – $0

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

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

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

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

[4] 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.

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

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

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

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

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

[10] The 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 non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the list at the Tier 3 copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed, and prescribing providers are notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a member is suffering from a health condition that may seriously jeopardize the member's life, health or ability to regain maximum function. Routine requests from physicians are processed and prescribing providers are notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted. For a copy of the 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.

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

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

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

[13] The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with 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 an Ambetter from Health Net Individual & Family Plan, go to **www.CoveredCA.com.**

Who is eligible?

To be eligible for a Health Net Ambetter Individual & Family Exchange plan, you must: (a) live in the Health Net Ambetter HMO service area for an Ambetter HMO plan; (b) be a citizen or national of the United States or an alien lawfully present in the United States; (c) not be incarcerated; and (d) 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 HMO 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 ages 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 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;
- Demonstrate that you had a material provision of your health coverage contract substantially violated by your health coverage issuer;
- Were receiving services under another health benefit plan from a contracting provider who no longer participates in that health plan for any of the following conditions: (a) an acute or serious condition; (b) a terminal illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contract's termination date or the effective date of coverage for a newly covered member;
- Demonstrate to Covered California that you did not enroll in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage;
- Are a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code;
- Were not allowed to enroll in a plan through Covered California due to the intentional, inadvertent or erroneous actions of Covered California;
- Gain or maintain status as an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, or are or become a dependent of an Indian, and are enrolled in or are enrolling on the same application as the Indian (you can change from one plan to another one time per month);

- It is determined by Covered California on a case-by-case basis that the qualified individual or enrollee, or their dependents, was not enrolled as a result of misconduct on the part of a non-Covered California entity providing enrollment assistance or conducting enrollment activities;
- It is demonstrated to Covered California, in accordance with guidelines issued by the Department of Health and Human Services, that the individual or enrollee meets other exceptional circumstances as Covered California may provide;
- 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;
- Provide satisfactory documentary evidence to Covered California to verify eligibility following termination of enrollment due to failure to verify status within the required time period or are under 100 percent of the Federal Poverty Level and did not enroll while waiting for the United States Department of Health and Human Services to verify citizenship, status as a national or lawful presence.
- 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);
- Were enrolled in any non-calendar year plan that expired or will expire, even if you or your dependent had the option to renew the plan. The date of the loss of coverage shall be the date of the expiration of the non-calendar year policy;
- Lost medically needy coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Lost pregnancy-related coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Gained access to new health benefit plans as a result of a permanent move;
- Were released from incarceration;
- Newly become a citizen or national of the United States or an alien lawfully present in the United States;
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a health benefit plan. Covered California must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for their employer's upcoming plan year to access this special enrollment period prior to the end of the coverage through the eligible employer-sponsored plan.
- 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

A 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 provisions after the enrollment effective date, you will be notified at least 60 days in advance.

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

Can benefits be terminated?

You may terminate your coverage by notifying Covered California or Health Net at least 14 days before the date that you request that the plan contract terminate. In such event, the plan contract will end at 12:01 a.m. 14 days after you notify Covered California or Health Net, on a later date that you request, or on an earlier date that you request if Health Net agrees to the earlier date. 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.) Subscribers and enrolled dependents who are receiving a Federal Advance Payment of Premium Tax Credit have a three-month grace period in lieu of the 30-day grace period. This plan will provide coverage for all allowable claims for the first month of a three-month grace period for non-payment of subscription charges. However, Health Net may suspend your coverage and pend claims for services rendered by health care providers in the second and third month of the three-month grace period, and Health Net may ultimately deny these claims unless subscription charges due for the term of coverage are paid in full by the end of the three-month grace period. If the entire amount of subscription charges due are paid before the end of the three-month grace period, coverage that was suspended will be reinstated to the last day of paid coverage. Providers whose claims are denied by Health Net may bill you for payment.
- You and/or your family member(s) cease being eligible (see the "Who is eligible?" section).
- You commit any act or practice which constitutes fraud or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include misrepresenting eligibility information about you or a dependent; presenting an invalid prescription or physician order; or misusing a Health Net member ID card (or letting someone else use it).

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

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

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

When Health Net can rescind or cancel a plan contract:

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

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

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

Cancellation of a plan contract
If the plan contract is canceled, you will be sent a notice of cancellation 30 days prior to the effective date of the cancellation.

Rescission of a plan contract
If the plan contract is rescinded, Health Net shall have no liability for the provision of coverage under the plan contract.

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

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

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

If the plan contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the termination that will:

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

If the plan contract is rescinded:

1. Health Net may revoke your coverage as if it never existed, and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recoverfrom 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 Exchange 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 **877-609-8711** 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 if I need a second opinion?

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

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

- The member's PCP or a referral physician is unable to diagnose the member's condition or test results are conflicting.

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

What are Health Net's premium ratios?

Health Net of California's 2023 ratio of premium costs to health services paid for Individual & Family HMO plans was 89.0 percent.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals, participating providers, and other health care providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or employees of any physician group, contract physician, hospital, or other health care provider. All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net, its agents or employees, or of physician groups, participating providers, any physician or hospital, or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of your plan.

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

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

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

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

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

To request continued care, 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 such a provider, subject to applicable copayments and any exclusions and limitations of this plan. You must request the coverage within 60 days of your effective date unless you can show that it was not reasonably possible to make the request within 60 days of your effective date and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are notcapitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

To request continued care, you will need to complete a Continuity of Care 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 ContactCenter 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 877-609-8711 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

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

When and how does Health Net pay my medical bills?

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

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

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

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

If your situation is not so severe: HMO plan members should call their primary care physician or physician group, or Health Net. You can also call 988, the national suicide and mental health crises hotline system.

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

Emergency care includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the

scope of 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. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Active labor means labor at the time that either of the following could reasonably be expected to occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of 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*.

All follow-up care after the emergency or urgency has passed and your condition is stable, must be provided or authorized by your primary care physician, physician group or Health Net, otherwise, it will not be covered by Health Net.

Am I liable for payment of certain services?

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

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

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

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*.

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

When you need to see a participating mental health professional, contact Health Net by calling the Customer Contact Center at the phone number on your Health Net ID card. Health Net will help you identify a participating mental health professional within the network, close to where you live or work, 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 Exchange *Plan Contract and Evidence of Coverage* 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 Health Care's Help Center at 1-888-466-2219; or (3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

CVS MinuteClinic services

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

You do not need prior authorization or a referral from your primary care physician or contracting physician group in order to obtain access to CVS MinuteClinic services. However, under the HMO plans, a referral from the contracting physician group or primary care physician is required for any specialist consultations. For more detailed information about CVS MinuteClinics, please refer to the Health Net Individual & Family Exchange *Plan Contract and Evidence of Coverage* or contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card.

Telehealth consultations through the select telehealth services provider

Health Net contracts with certain select telehealth services providers to provide telehealth services for medical, mental health 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

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

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

Maintenance prescriptions by mail order drug program

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

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

Note: Schedule II narcotic drugs are not covered through mail order. See the Health Net Individual & Family Exchange *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 brand name drugs, 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.

We specifically suggest to all Health Net participating providers, contracting PCPs and specialists that they refer to this List when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed on 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, and
- Physician recommendations.

To obtain a copy of Health Net's most current "Essential Drug List," please visit our website at **www.myhealthnetca.com,** or call Health Net's Customer Contact Center at **877-609-8711.** 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 drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the member to have special training or clinical monitoring for self- administration; or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply. Tier 4 drugs (Specialty drugs) are identified in the "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 HMO plan, you will not be required to use the step therapy process to continue using the prescription drug.

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the prescription drug prescribed by a health care provider for a member. For more information on the step therapy exception process, please see "Step Therapy Exception" in the 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 and Copayments" section of your *Plan Contract and EOC*. If an exception is denied, the drug is not covered, and you are responsible for the entire cost of the drug.

What is "prior authorization"?

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

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

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

Prescription drug program exclusions and limitations

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

- Allergy serum is covered as a medical benefit.
- Brand-name drugs that have generic equivalents are not covered without prior authorization from Health Net.
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, 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 and when you meet Health Net prior authorization coverage requirements. The prescribing physician must request and obtain prior authorization for coverage.
- Drugs prescribed to shorten the duration of the common cold.
- Experimental drugs (those that are labeled "Caution – Limited by federal law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental, you will have a right to 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 Exchange *Plan Contract and EOC*.

Acupuncture care program

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

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

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

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

All covered acupuncture services may be subject to verification of medical necessity by ASH Plans except:

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

Acupuncture care program exclusions and limitations

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

- Auxiliary aids and services are not covered;
- Services provided by an acupuncturist practicing outside California are not covered;

- Diagnostic radiology, including MRIs or thermography are not covered;
- X-rays, laboratory tests and X-ray second opinions 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 Exchange *Plan Contract and Evidence of Coverage*.

Pediatric vision care program

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

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

Professional services	Copayment
Routine eye examination with dilation	$0[1]
Examination for contact lenses Standard contact lens fit and follow-up	$0[1]
Premium contact lens fit and follow-up	$0[1]
Limitation: [1]In accordance with professionally recognized standards of practice, this plan covers one complete vision examination once every calendar year. **Note:** Examination for contact lenses is in addition to the member's vision examination. There is no additional copayment for a contact lens follow-up visit after the initial fitting exam. Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one-time-use benefits. No remaining balance. Standard contact lenses include soft, spherical and daily wear contact lenses. Premium contact lenses include toric, bifocal, multifocal, cosmetic color, post-surgical, and gas permeable contact lenses.	
Materials (includes frames and lenses)	**Copayment**
Provider-selected frames (one every 12 months)	$0
Standard eyeglass lenses (one pair every 12 months) • Single vision, bifocal, trifocal, lenticular • Glass or plastic, including polycarbonate	$0
Optional lenses and treatments including: • UV treatment • Tint (fashion and gradient and glass-grey) • Standard plastic scratch coating • Photochromatic / transitions plastic • Standard anti-reflective coating • Polarized • Standard progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses • Select or ultra progressive lenses	$0
Premium progressive lenses	$0
Provider-selected contact lenses (in lieu of eyeglass lenses) • Extended wear disposables: up to 6-month supply of monthly or 2-week supply of disposable, single vision spherical or toric contact lenses • Daily wear/disposables: up to 3-month supply of daily disposables, single vision spherical contact lenses • Conventional: one pair from selection of provider-designated contact lenses • Medically necessary[2]	$0
[2]Contact lenses may be medically necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.	

Medically necessary contact lenses:

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

Pediatric vision care program exclusions and limitations

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

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

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

Pediatric dental services

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

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

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

Important: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you 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 read your benefit plan's *Plan Contract and Evidence of Coverage*.

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

Note: For the HMO Minimum Coverage plan, the calendar year deductible applies to all Pediatric Dental services except diagnostic and preventive services. Once the calendar year deductible is met for the HMO Minimum Coverage plan, your copayment is $0 for the noted covered services for the remainder of the calendar year.

Selecting a dentist

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

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

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

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

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

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

Specialist referrals

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

Referrals to specialists for orthodontic care

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

Medically necessary dental services

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

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

Emergency dental services

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

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

Code	Service	Copayment
Diagnostic		
D0120	Periodic oral evaluation – established patient, limited to 1 every 6 months	No charge
D0140	Limited oral evaluation – problem-focused	No charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge
D0150	Comprehensive oral evaluation – new or established patient	No charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No charge
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12-month period	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 1 series every 6 months	No charge
D0277	Vertical bitewings – 7 to 8 films	No charge
D0310	Sialography	No charge
D0320	Temporomandibular joint arthrogram, including injection, limited to a maximum of 3 per date of service	No charge
D0322	Tomographic survey, limited to twice in a 12-month period	No charge
D0330	Panoramic film, limited to once in a 36-month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery)	No charge
D0340	2D cephalometric radiographic image, limited to twice in a 12-month period per provider	No charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally, 1st limited to a maximum of 4 per date of service	No charge
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	2D cephalometric radiographic image – image capture only	No charge
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	No charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No charge
D0706	Intraoral – occlusal radiographic image – image capture only	No charge
D0707	Intraoral – periapical radiographic image – image capture only	No charge
D0708	Intraoral – bitewing radiographic image – image capture only	No charge
D0709	Intraoral – comprehensive series of radiographic images – image capture	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	Copayment
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 Amalgam – one surface, permanent, limited to once in a 36-month period	$25 $25
D2150	Amalgam – two surfaces, primary, limited to once in a 12-month period Amalgam – two surfaces, permanent, limited to once in a 36-month period	$30 $30
D2160	Amalgam – three surfaces, primary, limited to once in a 12-month period Amalgam – three surfaces, permanent, limited to once in a 36-month period	$40 $40
D2161	Amalgam – four or more surfaces, primary, limited to once in a 12-month period Amalgam – four or more surfaces, permanent, limited to once in a 36-month period	$45 $45
D2330	Resin-based composite – one surface, anterior primary, limited to once in a 12-month period Resin-based composite – one surface, anterior permanent, limited to once in a 36-month period	$30 $30
D2331	Resin-based composite – two surfaces, anterior primary, limited to once in a 12-month period Resin-based composite – two surfaces, anterior permanent, limited to once in a 36-month period	$45 $45
D2332	Resin-based composite – three surfaces, anterior primary, limited to once in a 12-month period Resin-based composite – three surfaces, anterior permanent, limited to once in a 36-month period	$55 $55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) primary, limited to once in a 12-month period Resin-based composite – four or more surfaces or involving incisal angle (anterior) permanent, limited to once in a 36-month period	$60 $60
D2390	Resin-based composite crown, anterior, primary, limited to once in a 12-month period Resin-based composite crown, anterior, permanent, limited to once in a 36-month period	$50 $50
D2391	Resin-based composite – one surface, posterior, primary, limited to once in a 12-month period Resin-based composite – one surface, posterior permanent, limited to once in a 36-month period	$30 $30
D2392	Resin-based composite – two surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – two surfaces, posterior, permanent, limited to once in a 36-month period	$40 $40

Code	Service	Copayment
D2393	Resin-based composite – three surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – three surfaces, posterior, permanent, limited to once in a 36-month period	$50 $50
D2394	Resin-based composite – four or more surfaces, posterior, primary, limited to once in a 12-month period Resin-based composite – four or more surfaces, posterior, permanent, limited to once in a 36-month period	$70 $70
D2710	Crown – resin-based composite (indirect), limited to once in a 5-year period	$140
D2712	Crown – ¾ resin-based composite (indirect), limited to once in a 5-year period	$190
D2721	Crown – resin with predominantly base metal, limited to once in a 5-year period	$300
D2740	Crown – porcelain/ceramic, limited to once in a 5-year period	$300
D2751	Crown – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300
D2781	Crown – ¾ cast predominantly base metal, limited to once in a 5-year period	$300
D2783	Crown – ¾ porcelain/ceramic, limited to once in a 5-year period	$310
D2791	Crown – full cast predominantly base metal, limited to once in a 5-year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration, limited to once in a 12-month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown – primary tooth, limited to once in a 12-month period	$95
D2930	Prefabricated stainless steel crown – primary tooth, limited to once in a 12-month period	$65
D2931	Prefabricated stainless steel crown – permanent tooth, limited to once in a 36-month period	$75
D2932	Prefabricated resin crown, primary, limited to once in a 12-month period Prefabricated resin crown, permanent, limited to once in a 36-month period	$75 $75
D2933	Prefabricated stainless steel crown with resin window, primary, limited to one in a 12-month period Prefabricated stainless steel crown with resin window, permanent, limited to one in a 36-month period	$80 $80
D2940	Protective restoration, limited to once per tooth in a 12-month period	$25
D2941	Interim therapeutic restoration – primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention – per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated, limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post – same tooth	$30
D2954	Prefabricated post and core in addition to crown, limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post – same tooth	$35
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework	$35
D2976	Band stabilization – per tooth	$40
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair by the same provider.	$50
D2989	Excavation of a tooth resulting in the determination of nonrestorability	$50
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration), removal of pulp coronal to the dentinocemental junction and application of medicament, limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development, limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) – anterior, primary tooth (excluding final restoration), limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration), limited to once per primary tooth	$55
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$195

(continued)

Code	Service	Copayment
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration), limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy – anterior	$240
D3347	Retreatment of previous root canal therapy – premolar	$295
D3348	Retreatment of previous root canal therapy – molar	$350
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.), limited to once per permanent tooth	$85
D3352	Apexification/recalcification – interim medication replacement only following D3351, limited to once per permanent tooth	$45
D3410	Apicoectomy anterior	$240
D3421	Apicoectomy premolar (first root)	$250
D3425	Apicoectomy molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350
D3430	Retrograde filling – per root	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80
D3471	Surgical repair of root resorption – anterior	$160
D3472	Surgical repair of root resorption – premolar	$160
D3473	Surgical repair of root resorption – molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth spaces per quadrant – once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth-bounded spaces per quadrant – once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration per site	$80
D4341	Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full-mouth, after oral evaluation	$40
D4355	Full-mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance, limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per member per provider; for members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		
D5110	Complete denture – maxillary, limited to once in a 5-year period from a previous complete, immediate or overdenture-complete denture	$300
D5120	Complete denture – mandibular, limited to once in a 5-year period from a previous complete, immediate or overdenture-complete denture	$300
D5130	Immediate denture – maxillary	$300
D5140	Immediate denture – mandibular	$300
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$300

Code	Service	Copayment
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$335
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth), limited to once in a 5-year period	$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5410	Adjust complete denture – maxillary, limited to once per date of service; twice in a 12-month period	$20
D5411	Adjust complete denture – mandibular, limited to once per date of service; twice in a 12-month period	$20
D5421	Adjust partial denture – maxillary, limited to once per date of service; twice in a 12-month period	$20
D5422	Adjust partial denture – mandibular, limited to once per date of service; twice in a 12-month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth – complete denture (each tooth), limited to a maximum of four per arch, per date of service; twice per arch in a 12-month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials – per tooth – limited to a maximum of three per date of service; twice per arch in a 12-month period	$50
D5640	Replace broken teeth – per tooth – limited to maximum of four per arch, per date of service; twice per arch in a 12-month period	$35
D5650	Add tooth to existing partial denture, limited to a maximum of three per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture – per tooth – limited to a maximum of three per date of service; twice per arch in a 12-month period	$60
D5730	Reline complete maxillary denture (chairside), limited to once in a 12-month period	$60
D5731	Reline complete mandibular denture (chairside), limited to once in a 12-month period	$60
D5740	Reline maxillary partial denture (chairside), limited to once in a 12-month period	$60
D5741	Reline mandibular partial denture (chairside), limited to once in a 12-month period	$60
D5750	Reline complete maxillary denture (laboratory), limited to once in a 12-month period	$90
D5751	Reline complete mandibular denture (laboratory), limited to once in a 12-month period	$90
D5760	Reline maxillary partial denture (laboratory), limited to once in a 12-month period	$80
D5761	Reline mandibular partial denture (laboratory), limited to once in a 12-month period	$80
D5850	Tissue conditioning, maxillary, limited to twice per prosthesis in a 36-month period	$30
D5851	Tissue conditioning, mandibular, limited to twice per prosthesis in a 36-month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture – complete maxillary	$300
D5864	Overdenture – partial maxillary	$300
D5865	Overdenture – complete mandibular	$300
D5866	Overdenture – partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial prosthetics		
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350

(continued)

Code	Service	Copayment
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification, limited to twice in a 12-month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification, limited to twice in a 12-month period	$145
D5960	Speech aid prosthesis, modification, limited to twice in a 12-month period	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
Implant services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Surgical access to an implant body (second stage implant surgery)	$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar – implant supported or abutment supported	$350
D6056	Prefabricated abutment – includes modification and placement	$135
D6057	Custom fabricated abutment – includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315

Code	Service	Copayment
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported crown (porcelain fused to high noble alloys)	$335
D6067	Implant supported crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown – porcelain fused to noble alloys	$335
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$335
D6085	Interim implant crown	$300
D6086	Implant supported crown – predominantly base alloys	$340
D6087	Implant supported crown – noble alloys	$340
D6088	Implant supported crown – titanium and titanium alloys	$340
D6089	Accessing and retorquing loose implant screw – per screw	$60
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown – titanium and titanium alloys	$295
D6095	Repair implant abutment, by report	$65
D6096	Removal of broken implant retaining screw	$60
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6105	Removal of implant body not requiring bone removal or flap elevation	$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	$350
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350

(continued)

Code	Service	Copayment
D6122	Implant supported retainer for metal FPD – noble alloys	$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95
D6198	Remove interim implant component	$110
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, fixed		
D6211	Pontic – cast predominantly base metal, limited to once in a 5-year period	$300
D6241	Pontic – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300
D6245	Pontic – porcelain/ceramic, limited to once in a 5-year period	$300
D6251	Pontic – resin with predominantly base metal, limited to once in a 5-year period	$300
D6721	Retainer crown – resin predominantly base metal – denture, limited to once in a 5-year period	$300
D6740	Retainer crown – porcelain/ceramic, limited to once in a 5-year period	$300
D6751	Retainer crown – porcelain fused to predominantly base metal, limited to once in a 5-year period	$300
D6781	Retainer crown – ¾ cast predominantly base metal, limited to once in a 5-year period	$300
D6783	Retainer crown – ¾ porcelain/ceramic, limited to once in a 5-year period	$300
D6784	Retainer crown – ¾ titanium and titanium alloys	$300
D6791	Retainer crown – full cast predominantly base metal, limited to once in a 5-year period	$300
D6930	Recement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral maxillofacial prosthetics		
D7111	Extraction, coronal remnants – primary tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth – soft tissue	$95
D7230	Removal of impacted tooth – partially bony	$145
D7240	Removal of impacted tooth – completely bony	$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Incisional biopsy of oral tissue – hard (bone, tooth), limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue – soft, limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth, permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report, limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization), limited to once in a 5-year period per arch	$350

Code	Service	Copayment
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue), limited to once per arch	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible), limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus, limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis, limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity, limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7509	Marsupialization of odontogenic cyst	$180
D7510	Incision and drainage of abscess – intraoral soft tissue, limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$70
D7520	Incision and drainage of abscess – extraoral soft tissue	$70
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue, limited to once per date of service	$45
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system, limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone, limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus – closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350

(continued)

Code	Service	Copayment
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Nonarthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – lavage and lysis of adhesions	$350
D7874	Arthroscopy – disc repositioning and stabilization	$350
D7875	Arthroscopy – synovectomy	$350
D7876	Arthroscopy – discectomy	$350
D7877	Arthroscopy – debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7961	Buccal / labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue – per arch, limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity, limited to once per quadrant per date of service	$100
D7979	Non-surgical sialolithotomy	$155
D7980	Surgical sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar, limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350

Code	Service	Copayment
Orthodontics		
	Medically necessary banded case (The copayment applies to a member's course of treatment as long as that member remains enrolled in this plan.)	$1,000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance – maxillary	
D8697	Repair of orthodontic appliance – mandibular	
D8698	Recement or re-bond fixed retainer – maxillary	
D8699	Recement or re-bond fixed retainer – mandibular	
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	
D8704	Replacement of lost or broken retainer – mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive general services		
D9110	Palliative treatment of dental pain – per visit	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures, limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45
D9222	Deep sedation/general anesthesia – first 15 minutes	$45
D9223	Deep sedation/general anesthesia – each subsequent 15-minute increment	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment	$60
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	$0
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	$20
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12-month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12-month period per quadrant.	$45
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis – mounted case (D9950)	$210
D9995	Teledentistry – synchronous, real-time encounter **Note:** Teledentistry is limited to twice in a twelve month period.	No charge
D9996	Teledentistry – asynchronous, information stored and forwarded to dentist for subsequent review **Note:** Teledentistry is limited to twice in a twelve month period.	No charge
D9997	Dental case management – patients with special health care needs	$0
D9999	Unspecified adjunctive procedure, by report	$0

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

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures or b) is inconsistent with generally accepted standards for dentistry.
- Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
- Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.
- House/extended care facility calls, once per member per date of service.
- One hospital or ambulatory surgical center call per day per provider per member.
- Anesthesia for members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services, deep sedation or general anesthesia services do not require prior authorization.
- Occlusal guards when medically necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition.
- The following services, if in the opinion of the attending dentist or Health Net are not medically necessary, will not be covered:
  - Temporomandibular joint treatment (TMJ).
  - Elective dentistry and cosmetic dentistry.
  - Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
  - Treatment of malignancies, cysts, neoplasms, or congenital malformations.
  - Prescription medications.
  - Hospital charges of any kind.
  - Loss or theft of full or partial dentures.
  - Any procedure of implantation.
  - Any experimental procedure.
  - General anesthesia or intravenous/conscious sedation, except as specified in the medical benefits section.
  - Services that cannot be performed because of the physical or behavioral limitations of the patient.
  - Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
  - Any procedure performed for the purpose of correcting contour, contact or occlusion.
  - Any procedure that is not specifically listed as a covered service.
  - Services that were provided without cost to the member by state government or an agency thereof, or any municipality, county or other subdivisions.
  - The cost of precious metals used in any form of dental benefits.
  - Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by their panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or their plan provider is a pedodontist/pediatric dentist.
  - Pediatric dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber could reasonably expect that a dental emergency situation did not exist.

Orthodontic benefits

This dental plan covers orthodontic benefits as described above. Orthodontic care is covered when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. Orthodontic treatment must be provided by a participating dentist.

Individual & Family Exchange Plans Exclusions and Limitations

Exclusions and limitations common to all Individual & Family Exchange plans

No payment will be made under the Health Net Individual & Family Exchange 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 Exchange *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.
- 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.[1]
- Treatment and services for temporomandibular joint disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework, and appliances.
- This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center, or other properly licensed medical facility as specified in the plan's *Plan Contract and EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.
- Dental care for individuals ages 19 and older. However, this plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise medically necessary. See the "Dental care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses except as set out under the pediatric 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 participating provider, physician group or a hospital to lesions of the skin or surgical incisions; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over-the-counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; and (g) orthotics and corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications), 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.

[1]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.

- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Treatment by immediate family members.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, a participating provider or the physician group, according to Health Net's procedures.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drugs, medical equipment or supplies that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs, or for contraception approved by the FDA).
- Routine foot care, unless prescribed for the treatment of diabetes or peripheral vascular disease.
- 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 Exchange *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 Exchange *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 member 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 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 conditions identified as a mental health and substance use disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, 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. 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. For information regarding requesting an independent medical review of a denial of coverage "What if I have a disagreement with Health Net?" earlier in this guide.
- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and 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 or 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 and Copayments" of your *Plan Contract and EOC* and may require prior authorization.
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or physician-directed and is obtained for the purposes of checking a member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment or examinations administered at the request of a third party, such as a school, camp or sports organization.
- The costs associated with participating in sports activities, including, but not limited to, yoga, rock climbing, hiking, and swimming, are not covered.
- Services required for the treatment of emergency care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your primary care physician or specialist physician is not covered under the CVS MinuteClinic benefit. Services or supplies obtained from a CVS MinuteClinic that are not specified as covered in the *Plan Contract and Evidence of Coverage* are excluded under this plan. CVS MinuteClinics are not intended to replace your primary care physician or specialist physician as your primary source of regular monitoring of chronic conditions, but MinuteClinics can, for example, provide a blood sugar test for diabetics, if needed.
- 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.
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by your physician group or Health Net or when you require emergency or urgently needed care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FLY017550EH00 (12/17)

Health Net Individual & Family Ambetter HMO Exchange Plans

PO BOX 989731
West Sacramento CA 95798-9731

877-609-8711 *(English)*
877-891-9050 *(Cantonese)*
877-339-8596 *(Korean)*
877-891-9053 *(Mandarin)*
800-331-1777 *(Spanish)*
877-891-9051 *(Tagalog)*
877-339-8621 *(Vietnamese)*

Assistance for the hearing and speech impaired

TTY users call 711.

www.MyHealthNetCA.com

COVERED CALIFORNIA

BKT065137EP01 (1/25)