*Health Net of California, Inc. (Health Net)*

Individual & Family Plans

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# Individual & Family Exchange Ambetter PPO Plans

THROUGH COVERED CALIFORNIA™

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myhealthnetca.com

**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.

# Health Net Individual & Family Coverage for You and Your Family

## Is an Ambetter PPO right for you?

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

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

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

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

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

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

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

We believe maintaining an ongoing relationship with a Physician who knows you well and whom you trust is an important part of a good health care program. That's why with Ambetter PPO, you are required to select a Primary Care Physician (PCP) for yourself and each member of your family, even though you may go directly to any provider without first seeing your PCP. When selecting a PCP, choose a participating physician close enough to your residence to allow reasonable access to medical care. Information on how to select a PCP and a listing of the participating physicians in the Health Net Ambetter PPO service area, are available on the Health Net website at www.myhealthnetca.com. You can also call 1-877-609-8711 to request provider information or contact your Health Net authorized broker. PCPs include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

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

## Calendar year deductible

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

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

You will be notified by us of your deductible accumulation for each

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

## Out-of-pocket maximum

Copayments and deductibles that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum (OOPM). The family OOPM is equal to two times the individual OOPM. After you or your family members meet your OOPM, you pay no additional amounts for covered services and supplies for the balance of the calendar year. Once an individual member in a family satisfies the individual OOPM, the remaining enrolled family members must continue to pay the copayments and deductibles until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family OOPM or (b) each enrolled family member individually satisfies the individual OOPM. You are responsible for all charges related to services or supplies not covered by the health plan. Payments for services or supplies not covered by this plan will not be applied to this yearly OOPM. Any deductible, copayments or coinsurance paid for the services of a preferred provider will not apply toward the out-of-pocket maximum for out-of-network providers. In addition, deductible, copayments, or coinsurance paid for the services of an out-of-network provider will not apply toward the out-of-pocket maximum for preferred providers. For the Ambetter PPO plans, penalties paid for services which were not authorized as required do not apply to the yearly OOPM (see the "Prior Authorization Requirements" below). For the family OOPM to apply, you and your family must be enrolled as a family.

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

# Prior Authorization Requirements

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

## Services that require authorization include:

### *Inpatient facility admissions*[1]

Any type of facility, including but not limited to:

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

### *Outpatient procedures, services, or equipment*

1. Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
2. Acupuncture (after the initial consultation, continued treatment plans may need approval from ASH)
3. Ambulance: non-emergency air or ground ambulance services
4. Bariatric procedures
5. Bronchial thermoplasty
6. Capsule Endoscopy
7. Cardiovascular procedures
8. Clinical Trials
9. Diagnostic procedures including:
   - Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)

- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Positron Emission Tomography (PET)

- Cardiac Imaging
  - Coronary Computed Tomography Angiography (CCTA)
  - Multigated Acquisition (MUGA) scan
  - Myocardial Perfusion Imaging (MPI)
- Sleep studies (facility-based sleep testing)

10. Durable Medical Equipment (DME)
11. Ear, Nose and Throat (ENT) procedures
12. Enhanced External Counterpulsation (EECP)
13. Experimental/Investigational services and new technologies.
14. Gender affirming services
15. Interventional Pain management
    - Facet joint denervation, injection or block
    - Epidural spine injections
    - Sacroiliac (SI joint injection
    - Spinal cord stimulator
    - Sympathetic nerve block
16. Mental Health and Substance Use Disorder services other than office visits including
    - Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
    - Electroconvulsive Therapy (ECT)
    - Half-Day Partial Hospitalization
    - Intensive Outpatient Program (IOP)
    - Neuropsychological testing
    - Partial Hospital Program or Day Hospital (PHP)
    - Psychological testing
    - Transcranial Magnetic Stimulation (TMS)
17. Musculoskeletal procedures
    - Joint surgery
    - Spine surgery
18. Neuro stimulator
19. Neuropsychological Testing
20. Orthognathic procedures (includes TMJ treatment)
21. Orthotics (custom made items)
22. Pharmaceuticals
    - Outpatient prescription drugs
      - Most specialty drugs, including self-injectable drugs and hemophilia factors, must have prior authorization through the prescription drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Essential Drug List to identify which drugs require prior authorization. Urgent or emergent drugs that are medically necessary to begin immediately may be obtained at a retail pharmacy.
      - Other prescription drugs, as indicated in the Essential Drug List, may require prior authorization. Refer to the Essential Drug List to identify which drugs require prior authorization.
    - Certain physician- administered drugs, including newly approved drugs, whether administered in a physician office, free-standing infusion center, home-infusion, Outpatient Surgical Center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net website, www.myhealthnetca.com, for a list of physician-administered drugs that require prior authorization. Biosimilars are required in lieu of branded drugs, unless medically necessary.
23. Proprietary laboratory analysis
24. Prosthesis
25. Quantitative drug testing
26. Radiation therapy
27. Reconstructive and cosmetic surgery, services, and supplies such as:
    - Bone alteration or reshaping such as osteoplasty
    - Breast reductions and augmentations except when following a mastectomy (includes mastectomy for gynecomastia)
    - Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
    - Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
    - Excision, excessive skin, and subcutaneous tissue (including lipectomy and panniculectomy) of the

abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas

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

28. Testosterone therapy
29. Therapy (includes home setting)
    - Occupational therapy
    - Physical therapy
    - Speech therapy
30. Transplant and related services
31. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
32. Vestibuloplasty
33. Wound Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Timely Access to Care to Preferred Providers

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

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

For further information, please refer to the Ambetter PPO *Plan Contract and EOC* or contact the Health Net Customer Contact Center at the phone number on the back cover.

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

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Platinum 90 Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | None | $5,000 single / $10,000 family |
| Out-of-pocket maximum[5] | $5,000 single / $10,000 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $15 | 50% |
| Telehealth consultations through the select telehealth services provider[6] | $0 | Not covered |
| Specialist consultation | $30 | 50% |
| Medically necessary acupuncture | $15 | Not covered |
| Preventive care services[7] | $0 | Not covered |
| X-ray and diagnostic imaging | $30 | 50% |
| Laboratory procedures | $15 | 50% |
| Imaging (CT/PET scans, MRIs) | 10% | 50% |
| Rehabilitation and habilitation therapy | $15 | Not covered |
| **Outpatient services**<br>Outpatient surgery | 10% | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | 10% | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 10% | 50% |
| **Emergency services**<br>Emergency room services (copays waived if admitted) | Facility: $175;<br>Physician: $0 | Facility: $175 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $15 | 50% |
| Ambulance services (ground and air) | $150 | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | 10% | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $15<br>Other than office visit: 10% up to $15 | 50% |
| **Home health care services** (100 visits/year) | 10% | Not covered |
| **Other services**<br>Durable medical equipment | 10% | Not covered |
| Hospice service | $0 | 50% |

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

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

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

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

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

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

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

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

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

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

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

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

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



(1/26)

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Gold 80 Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Out-of-network benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | None | $5,000 single / $10,000 family |
| Out-of-pocket maximum[5] | $9,200 single / $18,400 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $40 | 50% |
| Telehealth consultations through the select telehealth services provider[6] | $0 | Not covered |
| Specialist consultation | $70 | 50% |
| Medically necessary acupuncture | $40 | Not covered |
| Preventive care services[7] | $0 | Not covered |
| X-ray and diagnostic imaging | $75 | 50% |
| Laboratory procedures | $40 | 50% |
| Imaging (CT/PET scans, MRIs) | 25% | 50% |
| Rehabilitation and habilitation therapy | $40 | Not covered |
| **Outpatient services**<br>Outpatient surgery | 30% | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | 30% | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 30% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: $350;<br>Physician: $0 | Facility: $350 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $40 | 50% |
| Ambulance services (ground and air) | $250 | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | 30% | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $40<br>Other than office visit: 20% up to $40 | 50% |
| **Home health care services** (100 visits/year) | 20% | Not covered |
| **Other services**<br>Durable medical equipment | 20% | Not covered |
| Hospice service | $0 | 50% |

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| **Prescription drug coverage**[8]<br>(up to a 30-day supply obtained through a participating pharmacy)<br>Tier 1 (most generics and low-cost preferred brands) | $18 | Not covered |
| Tier 2 (non-preferred generics and preferred brands) | $60 | Not covered |
| Tier 3 (non-preferred brands) | $85 | Not covered |
| Tier 4 (Specialty drugs) | 20% up to $250 / 30-day script | Not covered |
| **Pediatric dental**[9,10] Diagnostic and preventive services | $0 | Not covered |
| **Pediatric vision**[9,11] Eye exam | $0 | Not covered |
| Glasses | 1 pair per year – $0 | Not covered |

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

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

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

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

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

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

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

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

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

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

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



(1/26)

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Silver 70 Ambetter PPO

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

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The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $5,200 single / $10,400 family | $10,400 single / $20,800 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $9,800 single / $19,600 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $50 (ded. waived) | 50% |
| Telehealth consultations through the select telehealth services provider[6] | $0 (ded. waived) | Not covered |
| Specialist consultation | $90 (ded. waived) | 50% |
| Medically necessary acupuncture | $50 (ded. waived) | Not covered |
| Preventive care services[7] | $0 (ded. waived) | Not covered |
| X-ray and diagnostic imaging | $95 (ded. waived) | 50% |
| Laboratory procedures | $50 (ded. waived) | 50% |
| Imaging (CT/PET scans, MRIs) | $325 (ded. waived) | 50% |
| Rehabilitation and habilitation therapy | $50 (ded. waived) | Not covered |
| **Outpatient services**<br>Outpatient surgery | 30% (ded. waived) | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | Facility: 30%;[8]<br>Physician: 30% (ded. waived)[8] | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 30% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: $400 (ded. waived);<br>Physician: $0 (ded. waived) | Facility: $400 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $50 (ded. waived) | 50% |
| Ambulance services (ground and air) | $250 (ded. waived) | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | Facility: 30%;[8]<br>Physician: 30% (ded. waived)[8] | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $50 (ded. waived)<br>Other than office visit: $0 | Office visit: 50%<br>Other than office visit: 50% |
| **Home health care services** (100 visits/year) | $45 (ded. waived) | Not covered |
| **Other services**<br>Durable medical equipment | 20% (ded. waived) | Not covered |
| Hospice service | $0 (ded. waived) | 50% |
| **Prescription drug coverage**<br>Prescription drug calendar year deductible (per insured) | $50 single / $100 family | Not covered |

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| **Prescription drugs**[9]<br>(up to a 30-day supply obtained through a participating pharmacy)<br>Tier 1 (most generics and low-cost preferred brands) | $19 (Rx ded. waived) | Not covered |
| Tier 2 (non-preferred generics and preferred brands) | $60 (after Rx deductible) | Not covered |
| Tier 3 (non-preferred brands) | $90 (after Rx deductible) | Not covered |
| Tier 4 Specialty drugs (most self-injectables) | 20% up to $250 / 30-day script (after Rx deductible) | Not covered |
| **Pediatric dental**[10,11] Diagnostic and preventive services | $0 (ded. waived) | Not covered |
| **Pediatric vision**[10,12] Eye exam | $0 (ded. waived) | Not covered |
| Glasses | 1 pair per year – $0 (ded. waived) | Not covered |

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

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

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

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

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

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

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

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

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

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

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

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



(1/26)

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Silver 94 Ambetter PPO

The Silver 94 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for covered benefits and services. For a lower cost-share, please make sure you use providers (doctors, hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available through Covered CA in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | None | $5,000 single / $10,000 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $1,400 single / $2,800 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $5 | 50% |
| Telehealth consultations through the select telehealth services provide[6] | $0 | Not covered |
| Specialist consultation | $8 | 50% |
| Medically necessary acupuncture | $5 | Not covered |
| Preventive care services[7] | $0 | Not covered |
| X-ray and diagnostic imaging | $10 | 50% |
| Laboratory procedures | $10 | 50% |
| Imaging (CT/PET scans, MRIs) | $50 | 50% |
| Rehabilitation and habilitation therapy | $5 | Not covered |
| **Outpatient services**<br>Outpatient surgery | 10% | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | Facility: 10%;<br>Physician: 10%[8] | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 10% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: $50<br>Physician: $0 | Facility: $50 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $5 | 50% |
| Ambulance services (ground and air) | $30 | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | Facility: 10%;<br>Physician: 10%[8] | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $5<br>Other than office visit: $0 | Office visit: 50%<br>Other than office visit: 50% |
| **Home health care services** (100 visits/year) | $3 | Not covered |
| **Other services**<br>Durable medical equipment | 10% | Not covered |
| Hospice | $0 | 50% |

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| **Prescription drug coverage**<br>Prescription drugs[9]<br>(up to a 30-day supply obtained through a participating pharmacy)<br>Tier 1 (most generics and low-cost preferred brands) | $3 | Not covered |
| Tier 2 (non-preferred generics and preferred brands) | $10 | Not covered |
| Tier 3 (non-preferred brands) | $15 | Not covered |
| Tier 4 Specialty drugs (most self-injectables) | 10% up to $150 / 30-day script | Not covered |
| **Pediatric dental**[10,11] Diagnostic and preventive services | $0 | Not covered |
| **Pediatric vision**[10,12] Eye exam | $0 | Not covered |
| Glasses | 1 pair per year – $0 | Not covered |

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

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

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

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

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

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

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

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

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

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

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

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



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*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Silver 87 Ambetter PPO

The Silver 87 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for covered benefits and services. For a lower cost-share, please make sure you use providers (doctors, hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available through Covered CA in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $1,400 single / $2,800 family | $5,000 single / $10,000 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $3,350 single / $6,700 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $15 (ded. waived) | 50% |
| Telehealth consultations through the select telehealth services provider[6] | $0 (ded. waived) | Not covered |
| Specialist consultation | $25 (ded. waived) | 50% |
| Medically necessary acupuncture | $15 (ded. waived) | Not covered |
| Preventive care services[7] | $0 (ded. waived) | Not covered |
| X-ray and diagnostic imaging | $50 (ded. waived) | 50% |
| Laboratory procedures | $30 (ded. waived) | 50% |
| Imaging (CT/PET scans, MRIs) | $100 (ded. waived) | 50% |
| Rehabilitation and habilitation therapy | $15 (ded. waived) | Not covered |
| **Outpatient services**<br>Outpatient surgery | 20% (ded. waived) | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | Facility: 20%<br>Physician: 20%[8] | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 20% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: $200 (ded. waived)<br>Physician: $0 (ded. waived) | Facility: $200 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $15 (ded. waived) | 50% |
| Ambulance services (ground and air) | $75 (ded. waived) | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | Facility: 20%;<br>Physician: 20%[8] | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $15 (ded. waived)<br>Other than office visit: $0 (ded. waived) | 50% |
| **Home health care services** (100 visits/year) | $15 (ded. waived) | Not covered |
| **Other services**<br>Durable medical equipment | 15% (ded. waived) | Not covered |
| Hospice | $0 (ded. waived) | 50% |

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| **Prescription drug coverage**<br>Prescription drug calendar year deductible (per insured) | $50 single / $100 family | Not covered |
| **Prescription drugs**[9]<br>(up to a 30-day supply obtained through a participating pharmacy)<br>Tier 1 (most generics and low-cost preferred brands) | $8 (ded. waived) | Not covered |
| Tier 2 (non-preferred generics and preferred brands) | $25 per script (after Rx ded.) | Not covered |
| Tier 3 (non-preferred brands) | $45 per script (after Rx ded.) | Not covered |
| Tier 4 Specialty drugs (most self-injectables) | 15% up to $150 per script (after Rx ded.) | Not covered |
| **Pediatric dental**[10,11] Diagnostic and preventive services | $0 | Not covered |
| **Pediatric vision**[10,12] Eye exam | $0 | Not covered |
| Glasses | 1 pair every 12 months – $0 | Not covered |

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

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

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

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

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

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

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

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

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

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

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

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

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



(1/26)_FED CSR

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Silver 73 Ambetter PPO

The Silver 73 Ambetter PPO health plan utilizes the **Ambetter PPO** provider network for covered benefits and services. For a lower cost-share, please make sure you use providers (doctors, hospitals, etc.) in the Ambetter PPO provider network. **Ambetter PPO** is available through Covered CA in Los Angeles, Orange, Sacramento, San Diego, and Yolo counties, and parts of Placer, Riverside and San Bernardino counties. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $5,200 single / $10,400 family | $10,400 single / $20,800 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $8,100 single / $16,200 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $50 (ded. waived) | 50% |
| Telehealth consultations through the select telehealth services provider[6] | $0 (ded. waived) | Not covered |
| Specialist consultation | $90 (ded. waived) | 50% |
| Medically necessary acupuncture | $50 (ded. waived) | Not covered |
| Preventive care services[7] | $0 (ded. waived) | Not covered |
| X-ray and diagnostic imaging | $95 (ded. waived) | 50% |
| Laboratory procedures | $50 (ded. waived) | 50% |
| Imaging (CT/PET scans, MRIs) | $325 (ded. waived) | 50% |
| Rehabilitation and habilitation therapy | $50 (ded. waived) | Not covered |
| **Outpatient services**<br>Outpatient surgery | 30% (ded. waived) | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | Facility: 30%;<br>Physician: 30%[8] | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 30% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: $400 (ded. waived)<br>Physician: $0 (ded. waived) | Facility: $400 (ded. waived);<br>Physician: $0 (ded. waived) |
| Urgent care | $50 (ded. waived) | 50% |
| Ambulance services (ground and air) | $250 (ded. waived) | Payable at the Preferred Provider level of benefits (ded. waived) |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | Facility: 30%;<br>Physician: 30%[8] | 50% |
| Mental/Behavioral health/Substanceuse disorder (outpatient) | Office visit: $50 (ded. waived)<br>Other than office visit: $0 (ded. waived) | 50% |
| **Home health care services** (100 visits/year) | $40 (ded. waived) | Not covered |
| **Other services**<br>Durable medical equipment | 20% (ded. waived) | Not covered |
| Hospice | $0 (ded. waived) | 50% |

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| **Prescription drug coverage**<br>Prescription drug calendar year deductible (per insured) | $50 single / $100 family | Not covered |
| **Prescription drugs**[9]<br>(up to a 30-day supply obtained through a participating pharmacy)<br>Tier 1 (most generics and low-cost preferred brands) | $19 (ded. waived) | Not covered |
| Tier 2 (non-preferred generics and preferred brands) | $55 per script (after Rx ded.) | Not covered |
| Tier 3 (non-preferred brands) | $85 per script (after Rx ded.) | Not covered |
| Tier 4 Specialty drugs (most self-injectables) | 20% up to $250 per script (after Rx ded.) | Not covered |
| **Pediatric dental**[10,11] Diagnostic and preventive services | $0 | Not covered |
| **Pediatric vision**[10,12] Eye exam | $0 | Not covered |
| Glasses | 1 pair per year – $0 (ded. waived) | Not covered |

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

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

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

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

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

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

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

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

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

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

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

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



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*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Bronze 60 Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $5,800 single / $11,600 family | $11,600 single / $23,200 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $9,800 single / $19,600 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | $60 (ded. waived) | 50% |
| Telehealth consultations through the select telehealth services provider[7] | $0 (ded. waived) | Not covered |
| Specialist consultation | Visits 1–3: $95 (ded. waived) /<br>Visits 4+: $95 (ded. applies)[6] | 50% |
| Medically necessary acupuncture | $60 (ded. waived) | Not covered |
| Preventive care services[8] | $0 (ded. waived) | Not covered |
| X-ray and diagnostic imaging | 40%[9] | 50% |
| Laboratory procedures | $50 (ded. waived) | 50% |
| Imaging (CT/PET scans, MRIs) | 40%[9] | 50% |
| Rehabilitation and habilitation therapy | $60 (ded. waived) | Not covered |
| **Outpatient services**<br>Outpatient surgery | 40%[9] | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | 40%[9] | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 40%[9] | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: 40%[9] (ded. applies);<br>Physician: $0 (ded. waived) | Facility: 40%[9] (ded. applies);<br>Physician: $0 (ded. waived) |
| Urgent care | $60 (ded. waived) | 50% |
| Ambulance services (ground and air) | 40%[9] | Payable at the Preferred Provider level of benefits |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | 40%[9] | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: $60 (ded. waived)<br>Other than office visit: 40% up to $60 (ded. waived) | 50% |
| **Home health care services** (100 visits/year) | 40%[9] | Not covered |
| **Other services**<br>Durable medical equipment | 40%[9] | Not covered |
| Hospice service | $0 (ded. waived) | 50% |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



(1/26)

*Health Net of California Inc. (Health Net)*

# California Individual & Family Plans Available through Covered California™

## Bronze 60 HDHP Ambetter PPO

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

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The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $7,200 single / $14,400 family | $14,400 single / $28,800 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $7,200 single / $14,400 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | 0% | 50% |
| Telehealth consultations through the select telehealth services provider[6] | 0% | Not covered |
| Specialist consultation | 0% | 50% |
| Medically necessary acupuncture | 0% | Not covered |
| Preventive care services[7] | $0 (ded. waived) | Not covered |
| X-ray and diagnostic imaging | 0% | 50% |
| Laboratory procedures | 0% | 50% |
| Imaging (CT/PET scans, MRIs) | 0% | 50% |
| Rehabilitation and habilitation therapy | 0% | Not covered |
| **Outpatient services**<br>Outpatient surgery | 0% | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | 0% | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 0% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | Facility: 0%; Physician: 0% | Facility: 0%; Physician: 0% |
| Urgent care | 0% | 50% |
| Ambulance services (ground and air) | 0% | Payable at the Preferred Provider level of benefits |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | 0% | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: 0%<br>Other than office visit: 0% | 50% |
| **Home health care services** (100 visits/year) | 0% | Not covered |
| **Other services**<br>Durable medical equipment | 0% | Not covered |
| Hospice service | 0% | 50% |

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

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

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

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

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

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

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

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

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

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

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

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



(1/26)

## Minimum Coverage Ambetter PPO

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

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

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments (also called coinsurance) are usually billed after the service is received. Covered services for medical conditions and mental health and substance use disorders provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth services will be covered only when performed by a preferred provider.

| Benefit description | Member(s) responsibility | |
|---|---|---|
| | In-network[1,2] | Out-of-network[1,3] |
| Unlimited lifetime maximum. Benefits are subject to a deductible unless noted. | | |
| **Plan maximums**<br>Calendar year deductible[4] | $10,600 single / $21,200 family | $21,200 individual/$42,400 family |
| Out-of-pocket maximum (includes calendar year deductible)[5] | $10,600 single / $21,200 family | $25,000 single / $50,000 family |
| **Professional services**<br>Office visit | Visits 1–3: 0% (ded. waived) /<br>Visits 4+: 0% (ded. applies)[6] | 50% |
| Telehealth consultations through the select telehealth services provider[7] | Visits 1–3: 0% (ded. waived) /<br>Visits 4+: 0% (ded. applies)[6] | Not covered |
| Specialist consultation | 0% | 50% |
| Medically necessary acupuncture | Visits 1–3: 0% (ded. waived) /<br>Visits 4+: 0% (ded. applies)[6] | Not covered |
| Preventive care services[8] | $0 (ded. waived) | Not covered |
| Laboratory procedures, X-ray and diagnostic imaging | 0% | 50% |
| Rehabilitation and habilitation therapy | 0% | Not covered |
| **Outpatient services**<br>Outpatient surgery | 0% | 50% |
| **Hospital services**<br>Inpatient hospital facility services (includes maternity) | 0% | 50% |
| Skilled nursing facility (maximum of 100 days per calendar year for each member) | 0% | 50% |
| **Emergency services**<br>Emergency room (copayment waived if admitted) | 0% facility / 0% physician<br>(ded. waived) | 0% facility / 0% physician<br>(ded. waived) |
| Urgent care | Visits 1–3: 0% (ded. waived) /<br>Visits 4+: 0% (ded. applies)[6] | 50% |
| Ambulance services (ground and air) | 0% | Payable at the Preferred Provider level of benefits |
| **Mental/Behavioral health/Substance use disorder services**<br>Mental/Behavioral health/Substance use disorder (inpatient) | 0% | 50% |
| Mental/Behavioral health/Substance use disorder (outpatient) | Office visit: Visits 1–3: 0% (ded. waived) / Visits 4+: 0% (ded. applies)[6]<br>Other than office visit: 0% | 50% |
| **Home health care services** (100 visits/year) | 0% | Not covered |
| **Other services**<br>Durable medical equipment | 0% | Not covered |
| Hospice service | 0% | 50% |

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

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

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

[3]Please refer to the *Plan Contract and EOC* for which you can use to search for a particular drug, out-of-network reimbursement methodology.

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

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

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

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

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

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

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

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

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



(1/26)

# Important Things to Know About Your Medical Coverage

## How to apply

To apply for an Ambetter from Health Net Individual & Family Exchange 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 PPO service area for an Ambetter PPO 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 PPO service area. The following persons are not eligible for coverage under this plan: (a) persons eligible for enrollment in a group plan with minimum essential coverage; (b) persons age 65 and older and eligible for Medicare benefits (except for dependent parents/stepparents as described above); (c) persons who are incarcerated; and (d) persons eligible for Medi-Cal, Healthy Families or other applicable state or federal programs.

For 2026 enrollment takes place November 1, 2025, to January 31, 2026, 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 the Exchange.
- 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.
- Were not provided timely notice of an event that triggers eligibility for a special enrollment period.

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;
- 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

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

## How does the monthly billing work?

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

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

## Can benefits be terminated?

You may terminate your coverage by notifying Covered California or Health Net at least 14 days before the date that you request that the *Plan Contract and EOC* terminate. In such event, the *Plan Contract and EOC* 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;
6. Include a Right to Request Review form. You have 180 days from the date of the Notice of Cancellation, Rescission or Nonrenewal to submit the Right to Request form to Health Net and/or the Department of Managed Health Care.

If the *Plan Contract* is rescinded:

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

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

## Are there any renewal provisions?

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

## Does Health Net coordinate benefits?

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

## What is utilization review?

Health Net makes medical care covered under our Individual & Family 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 **800-839-2172** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(888-466-2219)** and a **TDD** line **(877-688-9891)** for the hearing and speech impaired. The department's Internet website, **www.dmhc.ca.gov,** has complaint forms, IMR application forms and instructions online.

## What are Health Net's premium ratios?

Health Net of California's 2024 ratio of premium costs to health services paid for Individual & Family PPO plans was 86.6 percent.

## What is the relationship of the involved parties?

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

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

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

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

The following conditions are eligible for continuation of care:

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

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

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

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

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

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

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

## Do providers limit services for reproductive care?

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

## What is the method of provider reimbursement?

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

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

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

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

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

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

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

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

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

**If your situation is not so severe:** This plan covers care from in-network providers and out-of-network providers. You do not need a referral. You can also call 988, the national suicide and mental health crises hotline system. **When you use an out-of-network provider, benefits are substantially reduced and you will incur a significantly higher out-of-pocket expense.** This is because the cost-sharing for the out-of-network benefit is typically higher than for the in-network benefit. Plus, you are responsible for the difference between the amount the out-of-network provider bills and the Maximum Allowable Amount (MAA).

Emergency care includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of their license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Active labor means labor at the time that either of the following could reasonably be expected to occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of their license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capacity of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.

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

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

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

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

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

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

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

We will not release your medical records or other confidential information to anyone, such as

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

### *Privacy practices*

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

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

## How does Health Net deal with new technologies?

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

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

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

## What are Health Net's utilization management processes?

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

### *Prior authorization*

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

### *Concurrent review*

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

### *Discharge planning*

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

### *Retrospective review*

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

### *Care or case management*

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

# Additional Product Information

## Mental health and substance use disorders

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

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

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

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

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

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

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

## Telehealth consultations through the select telehealth services provider

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

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

## Prescription drug program

You must purchase covered drugs at a participating pharmacy in the Health Net Ambetter Pharmacy Network except for emergency or urgently needed care. Not all pharmacies that contract with

Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency or urgently needed care, only those pharmacies specifically identified as participating in the Ambetter Pharmacy Network may provide the prescription drugs benefit under this plan. For a list of pharmacies participating in the Ambetter Pharmacy Network, call our Health Net Customer Contact Center or visit our website at www.myhealthnetca.com. Pharmacies that are not in the Ambetter Pharmacy Network are out-of-network pharmacies under this plan. Prescription drug covered expenses are the lesser of Health Net contracted pharmacy rate or the pharmacy's cost of the prescription for covered prescription drugs.

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

### *Prescription Drug Deductible*

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

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

### *Preventive Drugs*

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member, and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force (USPSTF) A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

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

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

### *Maintenance prescriptions by mail order drug program*

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

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

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

**The Health Net Essential Drug List: Tier 1 drugs (most generic drugs and low cost preferred brand name drugs and Tier 2 drugs (non-preferred brand name drugs, preferred brand name drugs, drugs recommended**

**by Health Net's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost).**

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

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

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

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

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

### *Tier 3 drugs*

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

### *Tier 4 drugs (Specialty drugs)*

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

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

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

### *Step Therapy*

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

### *Step Therapy Exception*

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

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

### *What is "prior authorization"?*

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

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

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

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

## Prescription drug program exclusions and limitations

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

- Allergy serum is covered as a medical benefit.
- Brand-name drugs that have generic equivalents are not covered without prior authorization from Health Net.
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers, and diabetic supplies. No other devices are covered even if prescribed by a participating physician.
- Drugs prescribed for the treatment of obesity are not covered, except when medically necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. The prescribing physician must request and obtain prior authorization for coverage.
- Drugs prescribed to shorten the duration of the common cold.
- Experimental drugs (those that are labeled "Caution – Limited by federal law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental, you will have a right to an Independent Medical Review. See the "What if I have a disagreement with Health Net?" section of this brochure for additional information.
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices and pen needles.

- 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.
- 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 EOC*.

## Pediatric vision care program

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

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

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

### *Contact lenses*

Coverage of contact lenses is subject to all applicable exclusions and limitations.

| Vision Services Benefits | Copayment |
|---|---|
| **Routine eye exam limit: 1 per calendar year**<br>**Exam options:**<br>• Standard contact lens fit including follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions)<br>• Premium contact lens fit including follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable) | $0, deductible waived |
| **Lenses limit: 1 pair per calendar year**<br>Including:<br>• Single vision, bifocal, trifocal, lenticular<br>• Glass or plastic, including polycarbonate | $0, deductible waived |
| **Provider selected frames limit: 1 per calendar year** | $0, deductible waived |
| **Optional lenses and treatments**<br>Including:<br>• UV treatment<br>• Tint (fashion & gradient & glass-grey)<br>• Standard plastic scratch coating<br>• Photochromic / transitions plastic<br>• Standard and premium anti-reflective coating<br>• Polarized<br>• Standard and premium progressive lens<br>• Hi-index lenses<br>• Blended segment lenses<br>• Intermediate vision lenses | $0, deductible waived |
| **Provider selected contact lenses, a one year supply is covered every calendar year (in lieu of eyeglass lenses)**<br>• Standard (hard) contacts 1 contact per eye per every 12 months<br>• Monthly contacts (six-month supply)<br>• Bi-weekly (six-month supply)<br>• Dailies (three-month supply)<br>• Medically necessary[1] | $0, deductible waived |
| **Subnormal or low vision services and aids** – supplemental testing, follow-up care, and low vision aids | $0, deductible waived |

[1]Medically Necessary Contact Lenses:

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

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

Coverage for prescriptions for contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames.

## Pediatric vision care program exclusions and limitations

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

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

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

- Covered services and supplies provided by a provider who is not a participating vision provider
- Orthoptic or vision training;
- Charges for services and materials that Health Net determines to be non-medically necessary services, are excluded. One routine eye examination with dilation is covered every calendar year, and is not subject to medical necessity.
- Medical and/or surgical treatment of the eye, eyes or supporting structures; however, this is covered under the medical benefit;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date a member ceases to be covered under the *Plan Contract and EOC*, except when vision materials ordered before coverage ended are delivered,

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

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

## Pediatric dental services

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

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

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

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

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

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

### *Benefit Description*

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

| Code | Service | Member cost share |
|---|---|---|
| Diagnostic | | |
| **D0120** | Periodic oral evaluation – established patient limited to 1 every 6 months | No charge |
| **D0140** | Limited oral evaluation – problem focused | No charge |
| **D0145** | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No charge |
| **D0150** | Comprehensive oral evaluation – new or established patient | No charge |
| **D0160** | Detailed and extensive oral evaluation – problem focused, by report | No charge |
| **D0170** | Re-evaluation – limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12 month period | No charge |
| **D0171** | Re-evaluation – post-operative office visit | No charge |
| **D0180** | Comprehensive periodontal evaluation – new or established patient | No charge |
| **D0210** | X-rays intraoral – comprehensive series (including bitewings) limited to once per provider every 24 months | No charge |
| **D0220** | X-rays intraoral – periapical first film limited to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period. | No charge |
| **D0230** | X-rays intraoral – periapical each additional film limited to a maximum of 20 periapicals in a 12 month period | No charge |
| **D0240** | X-rays iIntraoral – occlusal film limited to 2 in a 6 month period | No charge |
| **D0250** | Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector – first film | No charge |
| **D0251** | Extraoral posterior dental radiographic image | No charge |
| **D0270** | X-rays bitewing – single film limited to once per date of service | No charge |
| **D0272** | X-rays bitewings – two films limited to once every 6 months | No charge |
| **D0273** | X-rays bitewings – three films | No charge |
| **D0274** | X-rays bitewings – four films – limited to once every 6 months | No charge |
| **D0277** | Vertical bitewings – 7 to 8 films | No charge |
| **D0310** | Sialography | No charge |
| **D0320** | Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service | No charge |
| **D0322** | Tomographic survey limited to twice in a 12 month period | No charge |
| **D0330** | Panoramic film limited to once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery) | No charge |
| **D0340** | 2D cephalometric radiographic image limited to twice in a 12 month period per provider | No charge |
| **D0350** | 2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service | No charge |
| **D0396** | 3D printing of a 3D dental surface scan | No charge |
| **D0460** | Pulp vitality tests | No charge |
| **D0470** | Diagnostic casts may be provided only if one of the above conditions is present | No charge |
| **D0502** | Other oral pathology procedures, by report | No charge |
| **D0601** | Caries risk assessment and documentation, with a finding of low risk | No charge |
| **D0602** | Caries risk assessment and documentation, with a finding of moderate risk | No charge |
| **D0603** | Caries risk assessment and documentation, with a finding of high risk | No charge |
| **D0701** | Panoramic radiographic image – image capture only | No charge |
| **D0702** | 2-D cephalometric radiographic image – image capture only | No charge |
| **D0703** | 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only | No charge |
| **D0705** | Extra-oral posterior dental radiographic image – image capture only | No charge |
| **D0706** | Intraoral – occlusal radiographic image – image capture only | No charge |
| **D0707** | Intraoral – periapical radiographic image – image capture only | No charge |
| **D0708** | Intraoral – bitewing radiographic image – image capture only | No charge |
| **D0709** | Intraoral – complete comprehensive series of radiographic images – image capture only | No charge |
| **D0801** | 3D Intraoral surface scan - direct | No charge |
| **D0802** | 3D dental surface scan - indirect | No charge |
| **D0803** | 3D facial surface scan - direct | No charge |
| **D0804** | 3D facial surface scan - indirect | No charge |
| **D0999** | Office visit fee – per visit (Unspecified diagnostic procedure, by report) | No charge |

| Code | Service | Member cost share |
|---|---|---|
| **Preventive** | | |
| **D1110** | Prophylaxis – adult limited to once in a 12 month period | No charge |
| **D1120** | Prophylaxis – child limited to once in a 6 month period | No charge |
| **D1206** | Topical fluoride varnish limited to once in a 6 month period | No charge |
| **D1208** | Topical application of fluoride excluding varnish limited to once in a 6 month period | No charge |
| **D1310** | Nutritional counseling for control of dental disease | No charge |
| **D1320** | Tobacco counseling for the control and prevention of oral disease | No charge |
| **D1321** | Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high–risk substance use | No charge |
| **D1330** | Oral hygiene instructions | No charge |
| **D1351** | Sealant – per tooth limited to first, second and third permanent molars that occupy the second molar position | No charge |
| **D1352** | Preventive resin restoration in a moderate to high caries risk patient – permanent tooth limited to first, second and third permanent molars that occupy the second molar position | No charge |
| **D1353** | Sealant repair – per tooth | No charge |
| **D1354** | Interim caries arresting medicament application – per tooth | No charge |
| **D1355** | Caries preventive medicament application – per tooth | No charge |
| **D1510** | Space maintainer – fixed – unilateral limited to once per quadrant | No charge |
| **D1516** | Space maintainer – fixed – bilateral, maxillary | No charge |
| **D1517** | Space maintainer – fixed – bilateral, mandibular | No charge |
| **D1520** | Space maintainer – removable – unilateral limited to once per quadrant | No charge |
| **D1526** | Space maintainer – removable – bilateral, maxillary | No charge |
| **D1527** | Space maintainer – removable – bilateral, mandibular | No charge |
| **D1551** | Re–cement or re–bond bilateral space maintainer – maxillary | No charge |
| **D1552** | Re–cement or re–bond bilateral space maintainer – mandibular | No charge |
| **D1553** | Re–cement or re–bond unilateral space maintainer – per quadrant | No charge |
| **D1556** | Removal of fixed unilateral space maintainer – per quadrant | No charge |
| **D1557** | Removal of fixed bilateral space maintainer – maxillary | No charge |
| **D1558** | Removal of fixed bilateral space maintainer – mandibular | No charge |
| **D1575** | Distal shoe space maintainer – fixed – unilateral –– per quadrant | No charge |
| **Restorative** | | |
| **D2140** | Amalgam – one surface, primary limited to once in a 12 month period | 20% |
| **D2140** | Amalgam – one surface, permanent limited to once in a 36 month period | 20% |
| **D2150** | Amalgam – two surfaces, primary limited to once in a 12 month period | 20% |
| **D2150** | Amalgam – two surfaces, permanent limited to once in a 36 month period | 20% |
| **D2160** | Amalgam – three surfaces, primary limited to once in a 12 month period | 20% |
| **D2160** | Amalgam – three surfaces, permanent limited to once in a 36 month period | 20% |
| **D2161** | Amalgam – four or more surfaces, primary limited to once in a 12 month period | 20% |
| **D2161** | Amalgam – four or more surfaces, permanent limited to once in a 36 month period | 20% |
| **D2330** | Resin–based composite – one surface, anterior, primary limited to once in a 12 month period | 20% |
| **D2330** | Resin–based composite – one surface, anterior, permanent limited to once in a 36 month period | 20% |
| **D2331** | Resin–based composite – two surfaces, anterior primary limited to once in a 12 month period | 20% |
| **D2331** | Resin–based composite – two surfaces, anterior permanent limited to once in a 36 month period | 20% |
| **D2332** | Resin–based composite – three surfaces, anterior primary limited to once in a 12 month period | 20% |
| **D2332** | Resin–based composite – three surfaces, anterior permanent limited to once in a 36 month period | 20% |
| **D2335** | Resin–based composite – four or more surfaces (anterior) primary limited to once in a 12 month period | 20% |
| **D2335** | Resin–based composite – four or more surfaces (anterior) permanent limited to once in a 36 month period | 20% |
| **D2390** | Resin–based composite crown, anterior, primary limited to once in a 12 month period | 20% |
| **D2390** | Resin–based composite crown, anterior, permanent limited to once in a 36 month period | 20% |
| **D2391** | Resin–based composite – one surface, posterior primary limited to once in a 12 month period | 20% |
| **D2391** | Resin–based composite – one surface, posterior permanent limited to once in a 36 month period | 20% |
| **D2392** | Resin–based composite – two surfaces, posterior; primary limited to once in a 12 month period | 20% |
| **D2392** | Resin–based composite – two surfaces, posterior; permanent limited to once in a 36 month period | 20% |

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

*(continued)*

| Code | Service | Member cost share |
|---|---|---|
| **D3310** | Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment | 50% |
| **D3320** | Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment | 50% |
| **D3330** | Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment | 50% |
| **D3331** | Treatment of root canal obstruction; non–surgical access | 50% |
| **D3333** | Internal root repair of perforation defects | 50% |
| **D3346** | Retreatment of previous root canal therapy – anterior | 50% |
| **D3347** | Retreatment of previous root canal therapy – premolar | 50% |
| **D3348** | Retreatment of previous root canal therapy – molar | 50% |
| **D3351** | Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth | 50% |
| **D3352** | Apexification/recalcification – interim medication replacement only following D3351. Limited to once per permanent tooth | 50% |
| **D3410** | Apicoectomy – anterior | 50% |
| **D3421** | Apicoectomy – premolar (first root) | 50% |
| **D3425** | Apicoectomy – molar (first root) | 50% |
| **D3426** | Apicoectomy (each additional root) | 50% |
| **D3428** | Bone graft in conjunction with periradicular surgery - per tooth, single site | 50% |
| **D3429** | Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site | 50% |
| **D3430** | Retrograde filling – per root | 50% |
| **D3431** | Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery | 50% |
| **D3471** | Surgical repair of root resorption – anterior | 50% |
| **D3472** | Surgical repair of root resorption – premolar | 50% |
| **D3473** | Surgical repair of root resorption – molar | 50% |
| **D3910** | Surgical procedure for isolation of tooth with rubber dam | 50% |
| **D3999** | Unspecified endodontic procedure, by report | 50% |
| **Periodontics** | | |
| **D4210** | Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months | 50% |
| **D4211** | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months | 50% |
| **D4249** | Clinical crown lengthening – hard tissue | 50% |
| **D4260** | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth spaces per quadrant – once per quadrant every 36 months | 50% |
| **D4261** | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant – once per quadrant every 36 months | 50% |
| **D4265** | Biologic materials to aid in soft and osseous tissue regeneration, per site | 50% |
| **D4341** | Periodontal scaling and root planing – four or more teeth per quadrant – once per quadrant every 24 months | 50% |
| **D4342** | Periodontal scaling and root planing – one to three teeth per quadrant – once per quadrant every 24 months | 50% |
| **D4346** | Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation | 50% |
| **D4355** | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | 50% |
| **D4381** | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | 50% |
| **D4910** | Periodontal maintenance limited to once in a calendar quarter | 20% |
| **D4920** | Unscheduled dressing change (by someone other than treating dentist). Once per member per provider; for members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261). | 50% |
| **D4999** | Unspecified periodontal procedure, by report | 50% |
| **Prosthodontics, removable** | | 50% |
| **D5110** | Complete denture – maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture | 50% |
| **D5120** | Complete denture – mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture | 50% |

| Code | Service | Member cost share |
|---|---|---|
| **D5130** | Immediate denture – maxillary | 50% |
| **D5140** | Immediate denture – mandibular | 50% |
| **D5211** | Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period | 50% |
| **D5212** | Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period | 50% |
| **D5213** | Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period | 50% |
| **D5214** | Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period | 50% |
| **D5221** | Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth) | 50% |
| **D5222** | Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth) | 50% |
| **D5223** | Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | 50% |
| **D5224** | Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | 50% |
| **D5410** | Adjust complete denture – maxillary limited to once per date of service; twice in a 12 month period | 50% |
| **D5411** | Adjust complete denture – mandibular limited to once per date of service; twice in a 12 month period | 50% |
| **D5421** | Adjust partial denture – maxillary limited to once per date of service; twice in a 12 month period | 50% |
| **D5422** | Adjust partial denture – mandibular limited to once per date of service; twice in a 12 month period | 50% |
| **D5511** | Repair broken complete denture base, mandibular | 50% |
| **D5512** | Repair broken complete denture base, maxillary | 50% |
| **D5520** | Replace missing or broken teeth – complete denture per tooth limited to a maximum of four, per arch, per date of service; twice per arch in a 12 month period | 50% |
| **D5611** | Repair resin denture base, mandibular | 50% |
| **D5612** | Repair resin denture base, maxillary | 50% |
| **D5621** | Repair cast framework, mandibular | 50% |
| **D5622** | Repair cast framework, maxillary | 50% |
| **D5630** | Repair or replace broken retentive/clasping materials– per tooth – limited to a maximum of three, per date of service; twice per arch in a 12 month period | 50% |
| **D5640** | Replace missing or broken teeth – partial denture – per tooth – limited to maximum of four, per arch, per date of service; twice per arch in a 12 month period | 50% |
| **D5650** | Add tooth to existing partial denture – per tooth – limited to a maximum of three, per date of service; once per tooth | 50% |
| **D5660** | Add clasp to existing partial denture – per tooth – limited to a maximum of three, per date of service; twice per arch in a 12 month period | 50% |
| **D5730** | Reline complete maxillary denture (chairside) limited to once in a 12 month period | 50% |
| **D5731** | Reline complete mandibular denture (chairside) limited to once in a 12 month period | 50% |
| **D5740** | Reline maxillary partial denture (chairside) limited to once in a 12 month period | 50% |
| **D5741** | Reline mandibular partial denture (chairside) limited to once in a 12 month period | 50% |
| **D5750** | Reline complete maxillary denture (laboratory) limited to once in a 12 month period | 50% |
| **D5751** | Reline complete mandibular denture (laboratory) limited to once in a 12 month period | 50% |
| **D5760** | Reline maxillary partial denture (laboratory) limited to once in a 12 month period | 50% |
| **D5761** | Reline mandibular partial denture (laboratory) limited to once in a 12 month period | 50% |
| **D5850** | Tissue conditioning, maxillary limited to twice per prosthesis in a 36 month period | 50% |
| **D5851** | Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions. | 50% |
| **D5862** | Precision attachment, by report | 50% |
| **D5863** | Overdenture – complete maxillary | 50% |
| **D5864** | Overdenture – partial maxillary | 50% |
| **D5865** | Overdenture – complete mandibular | 50% |
| **D5866** | Overdenture – partial mandibular | 50% |
| **D5899** | Unspecified removable prosthodontic procedure, by report | 50% |

*(continued)*

| Code | Service | Member cost share |
|---|---|---|
| **Maxillofacial Prosthetics** | | |
| **D5911** | Facial moulage (sectional) | 50% |
| **D5912** | Facial moulage (complete) | 50% |
| **D5913** | Nasal prosthesis | 50% |
| **D5914** | Auricular prosthesis | 50% |
| **D5915** | Orbital prosthesis | 50% |
| **D5916** | Ocular prosthesis | 50% |
| **D5919** | Facial prosthesis | 50% |
| **D5922** | Nasal septal prosthesis | 50% |
| **D5923** | Ocular prosthesis, interim | 50% |
| **D5924** | Cranial prosthesis | 50% |
| **D5925** | Facial augmentation implant prosthesis | 50% |
| **D5926** | Nasal prosthesis, replacement | 50% |
| **D5927** | Auricular prosthesis, replacement | 50% |
| **D5928** | Orbital prosthesis, replacement | 50% |
| **D5929** | Facial prosthesis, replacement | 50% |
| **D5931** | Obturator prosthesis, surgical | 50% |
| **D5932** | Obturator prosthesis, definitive | 50% |
| **D5933** | Obturator prosthesis, modification limited to twice in a 12 month period | 50% |
| **D5934** | Mandibular resection prosthesis with guide flange | 50% |
| **D5935** | Mandibular resection prosthesis without guide flange | 50% |
| **D5936** | Obturator prosthesis, interim | 50% |
| **D5937** | Trismus appliance (not for TMD treatment) | 50% |
| **D5951** | Feeding aid | 50% |
| **D5952** | Speech aid prosthesis, pediatric | 50% |
| **D5953** | Speech aid prosthesis, adult | 50% |
| **D5954** | Palatal augmentation prosthesis | 50% |
| **D5955** | Palatal lift prosthesis, definitive | 50% |
| **D5958** | Palatal lift prosthesis, interim | 50% |
| **D5959** | Palatal lift prosthesis, modification limited to twice in a 12 month period | 50% |
| **D5960** | Speech aid prosthesis, modification limited to twice in a 12 month period | 50% |
| **D5982** | Surgical stent | 50% |
| **D5983** | Radiation carrier | 50% |
| **D5984** | Radiation shield | 50% |
| **D5985** | Radiation cone locator | 50% |
| **D5986** | Fluoride gel carrier | 50% |
| **D5987** | Commissure splint | 50% |
| **D5988** | Surgical splint | 50% |
| **D5991** | Vesiculobullous disease medicament carrier | 50% |
| **D5999** | Unspecified maxillofacial prosthesis, by report | 50% |
| **Implant Services** | | 50% |
| **D6010** | Surgical placement of implant body: endosteal implant | 50% |
| **D6011** | Surgical access to an implant body (second stage implant surgery) | 50% |
| **D6012** | Surgical placement of interim implant body for transitional prosthesis; endosteal implant | 50% |
| **D6013** | Surgical placement of mini implant | 50% |
| **D6040** | Surgical placement: eposteal implant | 50% |
| **D6050** | Surgical placement: transosteal implant | 50% |
| **D6055** | Connecting bar – implant supported or abutment supported | 50% |
| **D6056** | Prefabricated abutment – includes modification and placement | 50% |
| **D6057** | Custom fabricated abutment – includes placement | 50% |

| Code | Service | Member cost share |
|---|---|---|
| **D6058** | Abutment supported porcelain/ceramic crown | 50% |
| **D6059** | Abutment supported porcelain fused to metal crown (high noble metal) | 50% |
| **D6060** | Abutment supported porcelain fused to metal crown (predominantly base metal) | 50% |
| **D6061** | Abutment supported porcelain fused to metal crown (noble metal) | 50% |
| **D6062** | Abutment supported cast metal crown (high noble metal) | 50% |
| **D6063** | Abutment supported cast metal crown (predominantly base metal) | 50% |
| **D6064** | Abutment supported cast metal crown (noble metal) | 50% |
| **D6065** | Implant supported porcelain/ceramic crown | 50% |
| **D6066** | Implant supported crown (porcelain fused to high noble alloys) | 50% |
| **D6067** | Implant supported crown (high noble alloys) | 50% |
| **D6068** | Abutment supported retainer for porcelain/ceramic FPD | 50% |
| **D6069** | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | 50% |
| **D6070** | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | 50% |
| **D6071** | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | 50% |
| **D6072** | Abutment supported retainer for cast metal FPD (high noble metal) | 50% |
| **D6073** | Abutment supported retainer for cast metal FPD (predominantly base metal) | 50% |
| **D6074** | Abutment supported retainer for cast metal FPD (noble metal) | 50% |
| **D6075** | Implant supported retainer for ceramic FPD | 50% |
| **D6076** | Implant supported retainer FPD (porcelain fused to high noble alloys) | 50% |
| **D6077** | Implant supported retainer for metal FPD (high noble alloys) | 50% |
| **D6080** | Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments | 50% |
| **D6081** | Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure | 50% |
| **D6082** | Implant supported crown – porcelain fused to predominantly base alloys | 50% |
| **D6083** | Implant supported crown – porcelain fused to noble alloys | 50% |
| **D6084** | Implant supported crown – porcelain fused to titanium and titanium alloys | 50% |
| **D6085** | Interim implant crown | 50% |
| **D6086** | Implant supported crown – predominantly base alloys | 50% |
| **D6087** | Implant supported crown – noble alloys | 50% |
| **D6088** | Implant supported crown – titanium and titanium alloys | 50% |
| **D6089** | Accessing and retorquing loose implant screw – per screw | 50% |
| **D6090** | Repair of implant/abutment supported prosthesis | 50% |
| **D6091** | Replacement of replaceable part of semi–precision or precision attachment of implant/abutment supported prosthesis, per attachment | 50% |
| **D6092** | Recement implant/abutment supported crown | 50% |
| **D6093** | Recement implant/abutment supported fixed partial denture | 50% |
| **D6094** | Abutment supported crown – titanium and titanium alloys | 50% |
| **D6096** | Removal of broken implant retaining screw | 50% |
| **D6097** | Abutment supported crown – porcelain fused to titanium and titanium alloys | 50% |
| **D6098** | Implant supported retainer – porcelain fused to predominantly base alloys | 50% |
| **D6099** | Implant supported retainer for FPD – porcelain fused to noble alloys | 50% |
| **D6100** | Surgical removal of implant body | 50% |
| **D6105** | Removal of implant body not requiring bone removal or flap elevation | 50% |
| **D6110** | Implant/abutment supported removable denture for edentulous arch – maxillary | 50% |
| **D6111** | Implant/abutment supported removable denture for edentulous arch – mandibular | 50% |
| **D6112** | Implant/abutment supported removable denture for partially edentulous arch – maxillary | 50% |
| **D6113** | Implant/abutment supported removable denture for partially edentulous arch – mandibular | 50% |
| **D6114** | Implant/abutment supported fixed denture for edentulous arch – maxillary | 50% |
| **D6115** | Implant/abutment supported fixed denture for edentulous arch – mandibular | 50% |
| **D6116** | Implant/abutment supported fixed denture for partially edentulous arch – maxillary | 50% |

*(continued)*

| Code | Service | Member cost share |
|---|---|---|
| **D6117** | Implant/abutment supported fixed denture for partially edentulous arch – mandibular | 50% |
| **D6118** | Implant/abutment supported interim fixed denture for edentulous arch – mandibular | 50% |
| **D6119** | Implant/abutment supported interim fixed denture for edentulous arch – maxillary | 50% |
| **D6120** | Implant supported retainer – porcelain fused to titanium and titanium alloys | 50% |
| **D6121** | Implant supported retainer for metal FPD – predominantly base alloys | 50% |
| **D6122** | Implant supported retainer for metal FPD – noble alloys | 50% |
| **D6123** | Implant supported retainer for metal FPD – titanium and titanium alloys | 50% |
| **D6180** | Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments | 50% |
| **D6190** | Radiographic/Surgical implant index, by report | 50% |
| **D6191** | Semi-precision abutment – placement | 50% |
| **D6192** | Semi-precision attachment – placement | 50% |
| **D6194** | Abutment supported retainer crown for FPD – titanium and titanium alloys | 50% |
| **D6195** | Abutment supported retainer – porcelain fused to titanium and titanium alloys | 50% |
| **D6197** | Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant | 50% |
| **D6198** | Remove interim implant component | 50% |
| **D6199** | Unspecified implant procedure, by report | 50% |
| **Prosthodontics, fixed** | | 50% |
| **D6211** | Pontic – cast predominantly base metal limited to once in a 5 year period | 50% |
| **D6241** | Pontic – porcelain fused to predominantly base metal limited to once in a 5 year period | 50% |
| **D6245** | Pontic – porcelain/ceramic limited to once in a 5 year period | 50% |
| **D6251** | Pontic – resin with predominantly base metal limited to once in a 5 year period | 50% |
| **D6721** | Retainer crown – resin predominantly base metal – denture limited to once in a 5 year period | 50% |
| **D6740** | Retainer crown – porcelain/ceramic limited to once in a 5 year period | 50% |
| **D6751** | Retainer crown – porcelain fused to predominantly base metal limited to once in a 5 year period | 50% |
| **D6781** | Retainer crown – ¾ cast predominantly base metal limited to once in a 5 year period | 50% |
| **D6783** | Retainer crown – ¾ porcelain/ceramic limited to once in a 5 year period | 50% |
| **D6784** | Retainer crown – ¾ titanium and titanium alloys | 50% |
| **D6791** | Retainer crown – full cast predominantly base metal limited to once in a 5 year period | 50% |
| **D6930** | Recement or re-bond fixed partial denture | 50% |
| **D6980** | Fixed partial denture repair necessitated by restorative material failure | 50% |
| **D6999** | Unspecified fixed prosthodontic procedure, by report | 50% |
| **Oral Maxillofacial Prosthetics** | | 50% |
| **D7111** | Extraction, coronal remnants – primary tooth | 50% |
| **D7140** | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 50% |
| **D7210** | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated | 50% |
| **D7220** | Removal of impacted tooth – soft tissue | 50% |
| **D7230** | Removal of impacted tooth – partially bony | 50% |
| **D7240** | Removal of impacted tooth – completely bony | 50% |
| **D7241** | Removal of impacted tooth – completely bony, with unusual surgical complications | 50% |
| **D7250** | Removal of residual tooth roots (cutting procedure) | 50% |
| **D7252** | Partial extraction for immediate implant placement | 50% |
| **D7259** | Nerve dissection | 50% |
| **D7260** | Oroantral fistula closure | 50% |
| **D7261** | Primary closure of a sinus perforation | 50% |
| **D7270** | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth – limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only | 50% |
| **D7280** | Exposure of an unerupted tooth | 50% |
| **D7283** | Placement of device to facilitate eruption of impacted tooth | 50% |
| **D7284** | Excisional biopsy of minor salivary glands | 50% |
| **D7285** | Incisional biopsy of oral tissue – hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service | 50% |

| Code | Service | Member cost share |
|---|---|---|
| **D7286** | Incisional biopsy of oral tissue – soft limited to removal of the specimen only; up to a maximum of 3 per date of service | 50% |
| **D7290** | Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment | 50% |
| **D7291** | Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment | 50% |
| **D7310** | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140–D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service. | 50% |
| **D7311** | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant | 50% |
| **D7320** | Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant | 50% |
| **D7321** | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant | 50% |
| **D7340** | Vestibuloplasty – ridge extension (secondary epithelialization) limited to once in a 5 year period per arch | 50% |
| **D7350** | Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch | 50% |
| **D7410** | Excision of benign lesion up 1.25 cm | 50% |
| **D7411** | Excision of benign lesion greater than 1.25 cm | 50% |
| **D7412** | Excision of benign lesion, complicated | 50% |
| **D7413** | Excision of malignant lesion up to 1.25 cm | 50% |
| **D7414** | Excision of malignant lesion greater than 1.25 cm | 50% |
| **D7415** | Excision of malignant lesion, complicated | 50% |
| **D7440** | Excision of malignant tumor – lesion diameter up to 1.25 cm | 50% |
| **D7441** | Excision of malignant tumor – lesion diameter greater than 1.25 cm | 50% |
| **D7450** | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm | 50% |
| **D7451** | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | 50% |
| **D7460** | Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm | 50% |
| **D7461** | Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm | 50% |
| **D7465** | Destruction of lesion(s) by physical or chemical method, by report | 50% |
| **D7471** | Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only | 50% |
| **D7472** | Removal of torus palatinus limited to once in a patient's lifetime | 50% |
| **D7473** | Removal of torus mandibularis limited to once per quadrant | 50% |
| **D7485** | Surgical reduction of osseous tuberosity limited to once per quadrant | 50% |
| **D7490** | Radical resection of maxilla or mandible | 50% |
| **D7509** | Marsupialization of odontogenic cyst | 50% |
| **D7510** | Incision and drainage of abscess – intraoral soft tissue limited to once per quadrant, same date of service | 50% |
| **D7511** | Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service | 50% |
| **D7520** | Incision and drainage of abscess – extraoral soft tissue | 50% |
| **D7521** | Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) | 50% |
| **D7530** | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service | 50% |
| **D7540** | Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service | 50% |
| **D7550** | Partial ostectomy /sequestrectomy for removal of non–vital bone limited to once per quadrant per date of service | 50% |
| **D7560** | Maxillary sinusotomy for removal of tooth fragment or foreign body | 50% |
| **D7610** | Maxilla – open reduction (teeth immobilized, if present) | 50% |
| **D7620** | Maxilla – closed reduction (teeth immobilized, if present) | 50% |
| **D7630** | Mandible – open reduction (teeth immobilized, if present) | 50% |
| **D7640** | Mandible – closed reduction (teeth immobilized, if present) | 50% |
| **D7650** | Malar and/or zygomatic arch – open reduction | 50% |
| **D7660** | Malar and/or zygomatic arch – closed reduction | 50% |
| **D7670** | Alveolus – closed reduction, may include stabilization of teeth | 50% |
| **D7671** | Alveolus – open reduction, may include stabilization of teeth | 50% |
| **D7680** | Facial bones – complicated reduction with fixation and multiple surgical approaches | 50% |
| **D7710** | Maxilla – open reduction | 50% |

*(continued)*

| Code | Service | Member cost share |
|---|---|---|
| **D7720** | Maxilla – closed reduction | 50% |
| **D7730** | Mandible – open reduction | 50% |
| **D7740** | Mandible – closed reduction | 50% |
| **D7750** | Malar and/or zygomatic arch – open reduction | 50% |
| **D7760** | Malar and/or zygomatic arch – closed reduction | 50% |
| **D7770** | Alveolus – open reduction stabilization of teeth | 50% |
| **D7771** | Alveolus, closed reduction stabilization of teeth | 50% |
| **D7780** | Facial bones – complicated reduction with fixation and multiple approaches | 50% |
| **D7810** | Open reduction of dislocation | 50% |
| **D7820** | Closed reduction of dislocation | 50% |
| **D7830** | Manipulation under anesthesia | 50% |
| **D7840** | Condylectomy | 50% |
| **D7850** | Surgical discectomy, with/without implant | 50% |
| **D7852** | Disc repair | 50% |
| **D7854** | Synovectomy | 50% |
| **D7856** | Myotomy | 50% |
| **D7858** | Joint reconstruction | 50% |
| **D7860** | Arthrotomy | 50% |
| **D7865** | Arthroplasty | 50% |
| **D7870** | Arthrocentesis | 50% |
| **D7871** | Non–arthroscopic lysis and lavage | 50% |
| **D7872** | Arthroscopy – diagnosis, with or without biopsy | 50% |
| **D7873** | Arthroscopy – lavage and lysis of adhesions | 50% |
| **D7874** | Arthroscopy – disc repositioning and stabilization | 50% |
| **D7875** | Arthroscopy – synovectomy | 50% |
| **D7876** | Arthroscopy – discectomy | 50% |
| **D7877** | Arthroscopy – debridement | 50% |
| **D7880** | Occlusal orthotic device, by report | 50% |
| **D7881** | Occlusal orthotic device adjustment | 50% |
| **D7899** | Unspecified TMD therapy, by report | 50% |
| **D7910** | Suture of recent small wounds up to 5 cm | 50% |
| **D7911** | Complicated suture – up to 5 cm | 50% |
| **D7912** | Complicated suture – greater than 5 cm | 50% |
| **D7920** | Skin graft (identify defect covered, location and type of graft) | 50% |
| **D7922** | Placement of intra–socket biological dressing to aid in hemostasis or clot stabilization, per site | 50% |
| **D7939** | Indexing for osteotomy using dynamic robotic assisted or dynamic navigation | 50% |
| **D7940** | Osteoplasty – for orthognathic deformities | 50% |
| **D7941** | Osteotomy – mandibular rami | 50% |
| **D7943** | Osteotomy – mandibular rami with bone graft; includes obtaining the graft | 50% |
| **D7944** | Osteotomy – segmented or subapical | 50% |
| **D7945** | Osteotomy – body of mandible | 50% |
| **D7946** | LeFort I (maxilla – total) | 50% |
| **D7947** | LeFort I (maxilla – segmented) | 50% |
| **D7948** | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft | 50% |
| **D7949** | LeFort II or LeFort III – with bone graft | 50% |
| **D7950** | Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla – autogenous or nonautogenous, by report | 50% |
| **D7951** | Sinus augmentation with bone or bone substitutes via a lateral open approach | 50% |
| **D7952** | Sinus augmentation via a vertical approach | 50% |
| **D7955** | Repair of maxillofacial soft and/or hard tissue defect | 50% |
| **D7961** | Buccal/labial frenectomy (frenulectomy) | 50% |
| **D7962** | Lingual frenectomy (frenulectomy) | 50% |

| Code | Service | Member cost share |
|---|---|---|
| **D7963** | Frenuloplasty limited to once per arch per date of service | 50% |
| **D7970** | Excision of hyperplastic tissue – per arch limited to once per arch per date of service | 50% |
| **D7971** | Excision of pericoronal gingiva | 50% |
| **D7972** | Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service | 50% |
| **D7979** | Non-surgical sialolithotomy | 50% |
| **D7980** | Surgical sialolithotomy | 50% |
| **D7981** | Excision of salivary gland, by report | 50% |
| **D7982** | Sialodochoplasty | 50% |
| **D7983** | Closure of salivary fistula | 50% |
| **D7990** | Emergency tracheotomy | 50% |
| **D7991** | Coronoidectomy | 50% |
| **D7995** | Synthetic graft – mandible or facial bones, by report | 50% |
| **D7997** | Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service | 50% |
| **D7999** | Unspecified oral surgery procedure, by report | 50% |
| **Orthodontics** | | 50% |
| | Medically necessary banded case (The copayment applies to a member's course of treatment as long as that member remains enrolled in this plan.) | 50% |
| **D8080** | Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion | |
| **D8091** | Comprehensive orthodontic treatment with orthognathic surgery | |
| **D8210** | Removable appliance therapy | |
| **D8220** | Fixed appliance therapy | |
| **D8660** | Pre-orthodontic treatment examination to monitor growth and development | |
| **D8670** | Periodic orthodontic treatment visit | |
| **D8671** | Periodic orthodontic treatment visit associated with orthognathic surgery | |
| **D8680** | Orthodontic retention (removal of appliances, construction, and placement of retainer(s)) | |
| **D8681** | Removable orthodontic retainer adjustment | |
| **D8696** | Repair of orthodontic appliance – maxillary | |
| **D8697** | Repair of orthodontic appliance – mandibular | |
| **D8698** | Recement or re-bond fixed retainer – maxillary | |
| **D8699** | Recement or re-bond fixed retainer – mandibular | |
| **D8701** | Repair of fixed retainer, includes reattachment – maxillary | |
| **D8702** | Repair of fixed retainer, includes reattachment – mandibular | |
| **D8703** | Replacement of lost or broken retainer – maxillary | |
| **D8704** | Replacement of lost or broken retainer – mandibular | |
| **D8999** | Unspecified orthodontic procedure, by report | |
| **Adjunctive General Services** | | |
| **D9110** | Palliative treatment of dental pain – per visit | 50% |
| **D9120** | Fixed partial denture sectioning | 50% |
| **D9210** | Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service | 50% |
| **D9211** | Regional block anesthesia | 50% |
| **D9212** | Trigeminal division block anesthesia | 50% |
| **D9215** | Local anesthesia in conjunction with operative or surgical procedures | 50% |
| **D9219** | Evaluation for moderate sedation, deep sedation or general anesthesia | 50% |
| **D9222** | Deep sedation/general anesthesia – first 15 minutes | 50% |
| **D9223** | Deep sedation/general anesthesia – each subsequent 15 minute increment | 50% |
| **D9230** | Inhalation of nitrous oxide/analgesia, anxiolysis | 50% |
| **D9239** | Intravenous moderate (conscious) sedation/analgesia – first 15 minutes | 50% |
| **D9243** | Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment | 50% |
| **D9248** | Non-intravenous conscious sedation | 50% |
| **D9310** | Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician | 50% |

*(continued)*

| Code | Service | Member cost share |
|---|---|---|
| **D9311** | Consultation with a medical health professional | No charge |
| **D9410** | House/Extended care facility call | 50% |
| **D9420** | Hospital or ambulatory surgical center call | 50% |
| **D9430** | Office visit for observation (during regularly scheduled hours) – no other services performed | 50% |
| **D9440** | Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit | 50% |
| **D9610** | Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service | 50% |
| **D9612** | Therapeutic parenteral drug, two or more administrations, different medications | 50% |
| **D9910** | Application of desensitizing medicament limited to once in a 12 month period; permanent teeth only | 50% |
| **D9930** | Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service | 50% |
| **D9950** | Occlusion analysis – mounted case limited to once in a 12 month period | 50% |
| **D9951** | Occlusal adjustment – limited. Limited to once in a 12 month period per quadrant | 50% |
| **D9952** | Occlusal adjustment – complete. Limited to once in a 12 month period following occlusion analysis– mounted case (D9950) | 50% |
| **D9995** | Teledentistry – synchronous; real–time encounter. Limited to twice in a 12 month period. | No charge |
| **D9996** | Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12 month period. | No charge |
| **D9997** | Dental case management – patients with special health care needs | No charge |
| **D9999** | Unspecified adjunctive procedure, by report | No charge |

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

## Pediatric dental care program exclusions and limitations

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

**Important:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service.

If you would like more information about dental coverage options, you may call member services at **866-249-2382** or your broker.

To fully understand your coverage, you may wish to carefully review the Health Net Individual & Family Exchange Plan Contract and Evidence of Coverages (EOC).

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

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.

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

# 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.
- Amounts charged by out-of-network providers for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as described in the Health Net Individual & Family Exchange *Plan Contract and Evidence of Coverages (EOC)*.
- Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.
- Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.
- Custodial care. Custodial care is not rehabilitative care and is provided to assist a patient in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net determines to be experimental or investigational, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net?" earlier in this guide.
- Services or supplies provided before the effective date of coverage and services or supplies provided after coverage through this plan has ended are not covered.
- Any charges incurred by a baby beyond 31 days (including the date of birth) are excluded unless the baby is enrolled under this health plan within 31 days (including the date of birth)

  If you do not enroll your newborn child within 31 days (including the date of birth), your child will be eligible to enroll under a special enrollment period within 60 days of birth.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Coverage for fertility preservation does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates).
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.[2]
- Treatment and services for temporomandibular joint disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework, and appliances.
- This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center, or other properly licensed medical facility as specified in the plan's *Plan Contract and EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.
- Dental care for individuals ages 19 and older. However, this plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses except as set out under the pediatric vision care program earlier in this guide.
- Services to reverse voluntary surgically induced infertility.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the plan does cover medically necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's *Plan Contract and EOC*.
- Immunizations and injections for foreign travel/occupational purposes.
- This health plan does not cover health care services, including supplies and prescription drugs, to a surrogate, including a member and/or family member acting as a surrogate or utilizing the services of a surrogate who may or may not be a member and/or family member, and any child born as a result of a surrogacy arrangement. This exclusion applies to all health care services, supplies and prescription drugs rendered to a surrogate. See the plan's *Plan Contract and EOC* for additional information:
- Although this plan covers durable medical equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (c) surgical dressings other than primary dressings that are applied by your physician or a hospital to lesions of the skin or surgical incisions; (d) Jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over the counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; (g) orthotics and corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications); and (h) other orthotics, including corrective, not mentioned above, unless medically necessary and custom made for the member. Corrective footwear must also be permanently attached to an orthotic device meeting coverage requirements under this health plan.
- Personal comfort items.
- Disposable supplies for home use, except certain disposable ostomy or urological supplies. See the *Plan Contract and EOC* for additional information.

[2]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).
- 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 medically necessary.
- 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 physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.
- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.
- Coverage for rehabilitation therapy is limited to medically necessary services provided by a plan-contracted physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of their license, to treat physical conditions and mental health and substance use disorders or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorders or autism. Coverage is subject to any required authorization from the plan or the member's medical group. The services must be based on a treatment plan authorized as required by the plan or the member's medical group.
- Coverage for habilitative services and/or therapy is limited to health care services and devices that help a person keep, learn, or improve skills and functioning for daily living, when provided by a member physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of their license, to treat physical conditions and mental health and substance use disorders, subject to any required authorization from Health Net or your physician group. The services must be based on a treatment plan authorized, as required, by Health Net or your physician group.
- The following types of treatment are only covered when provided in connection with covered treatment for a mental health and substance use disorders: (a) Treatment for co-dependency; (b) Treatment for psychological stress; and (c) Treatment of marital or family dysfunction. Treatment of neurocognitive disorders which include delirium, major and mild neurocognitive disorders and their subtypes and neurodevelopmental disorders are covered for medically necessary medical services but covered for accompanying behavioral and/or psychological symptoms or substance use disorder conditions only if amenable to psychotherapeutic, psychiatric, or substance use disorder treatment. This provision does not impair coverage for the medically necessary treatment of any mental health and substance use disorder identified as a mental health and substance use disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision as amended in the most recently issued edition or for medically necessary treatment as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date. In addition, Health Net will cover only those mental health and substance use disorder services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law. This plan covers medically necessary treatment for all essential health benefits, including "mental disorders" described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as amended in the most recently issued edition.
- Services that do not meet national standards for professional medical health or mental health and substance use disorder practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage, see "What if I have a disagreement with Health Net?" earlier in this guide.
  Hypnotherapy services are covered as part of a comprehensive evidence-based mental health treatment plan and provided by a licensed mental health provider with a medical hypnotherapy certification.

- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and mental health and substance use disorders.
- Psychological testing except as conducted by participating mental health professionals who are licensed and acting within the scope of their license for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated, computer-based reports, unless the scoring is performed by a provider qualified to perform it.
- Admission to a residential treatment center that is not medically necessary is excluded. Admissions that are not considered medically necessary and are not covered include, but are not limited to, admissions for custodial care, for a situational or environmental change only or as an alternative to placement in a foster home or halfway house.
- Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
- Medical and mental health and substance use disorder services as a condition of parole or probation, and court-ordered testing are limited to medically necessary covered services.
- Exception: The plan will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for a member when required or recommended for the member pursuant to a Community Assistance, Recovery, and Empowerment (CARE) agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. Services are provided to the member with no cost-share or prior authorization, except for prescription drugs. Prescription drugs are subject to the cost share shown in the "Schedule of Benefits" in the *Plan Contract and EOC* and may require prior authorization.
- Annual physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. An annual examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.
- The costs associated with participating in sports activities, including, but not limited to, yoga, rock climbing, hiking, and swimming, are not covered.
- 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.

**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។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ដាល់មាត់។ លោកអ្នកអាចស្ដាប់គេអានឯកសារឱ្យ 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’áłchíní (IFP) báhígíí éí kojį’ hojilnih 1-877-609-8711 (TTY: 711).

**Persian (Farsi)**

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

**Panjabi (Punjabi)**

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

**Russian**

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

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

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

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

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

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

FLY017550EH00 (12/17)

## Contact Us

For more information, please contact:

### *Health Net Individual & Family Ambetter PPO Plans*

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

### *Individual & Family Plans:*

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

### *Telecommunications device for the Hearing and Speech Impaired:*

800-995-0852

### *Visit www.myhealthnetca.com for the most up-to-date listings*

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