Summary *of* Benefits *and* Disclosure *Form*

Small Business Group
Full Network HMO Silver $50 • Plan G49

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of Benefits and Disclosure Form (SB/DF) answers basic questions about this versatile plan.

The coverage described in this SB/DF 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 SB/DF do not discriminate on the basis of race, ethnicity, nationality, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition or exclusion period.

If you have further questions, contact us:

 **By phone at 1-800-361-3366,**

 **Or write to: Health Net of California**
P.O. Box 9103
Van Nuys, CA 91409-9103

This *Summary of Benefits/Disclosure Form* (SB/DF) is only a summary of your health plan. The plan's *Evidence of Coverage* (EOC), which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You have the right to view the EOC prior to enrollment. To obtain a copy of the EOC, contact the Customer Contact Center at 1-800-361-3366. You should also consult the Group Hospital and *Professional Service Agreement* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB/DF and the plan's EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of Benefits and Coverage."

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How the Plan Works

Please read the following information so you will know from whom health care may be obtained, or what physician group to use.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

- When you enroll with Health Net, you choose a contracting physician group. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP).
- Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this designation, Health Net designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians, refer to your Health Net Group HMO Directory (Health Net HMO Directory). The Health Net HMO Directory is also available on the Health Net website at www.healthnet.com.
- Whenever you or a covered family member needs health care, your PCP will provide the medically necessary care. Specialist care is also available, when referred by your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians, are listed in the Health Net HMO Directory.

HOW TO CHOOSE A PHYSICIAN

Choosing a PCP is important to the quality of care you receive. To be comfortable with your choice, we suggest the following:

- Discuss any important health issues with your chosen PCP;
- Ask your PCP or the physician group about the specialist referral policies and hospitals used by the physician group; and
- Be sure that you and your family members have adequate access to medical care, by choosing a doctor located within 30 miles of your home or work.

SPECIALISTS AND REFERRAL CARE

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Refer to the "Mental Disorders and Chemical Dependency Care" section below for information about receiving care for Mental Disorders and Chemical Dependency.

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical, gynecological, reproductive or sexual health care from an in-network health care professional who specializes in obstetrics, gynecology or reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health, refer to your Health Net Group HMO Directory (Health Net HMO Directory). The Health Net HMO Directory is also available on the Health Net website at www.healthnet.com.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental disorders and chemical dependency conditions. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

CVS MINUTE CLINIC SERVICES

The CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which is designed to offer an alternative to a Physician’s office visit for the unscheduled treatment of non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. Visits to a CVS MinuteClinic are covered as shown in the "Schedule of Benefits and Coverage" section.

You do not need prior authorization or a referral from your primary care physician or contracting physician group in order to obtain access to CVS MinuteClinic services. However, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations. For more detailed information about CVS MinuteClinics, please refer to the plan's EOC or contact Health Net at the telephone number shown on the back cover.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *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**
- **Abortion**

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call the Health Net Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.

Schedule of Benefits and Coverage

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

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

Principal Benefits and Coverage Matrix

Deductibles..... Refer to Prescription drug coverage portion of this matrix

Lifetime maximums..... None

Out-of-Pocket Maximum

One member..... $7,800

Family (two or more members)..... $15,600

Once your payments for covered services and supplies equals the amount shown above in any one calendar year, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans), no additional copayments for covered services and supplies are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum.

Payments for services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

Professional Services

The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization Services" and "Outpatient Services" in this section to determine if any additional copayments may apply.

Office visit..... $50

Specialist consultations..... $70

Visit to CVS MinuteClinic..... $30

Primary care physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net..... $50

Specialist visit to member's home at your physician's discretion and in accordance with criteria set by Health Net..... $70

Surgeon or assistant surgeon services (in an inpatient setting)▲ 50%
Surgeon or assistant surgeon services (in a physician's office or outpatient facility)▲ 50%
Administration of anesthetics (in an inpatient setting) 50%
Administration of anesthetics (in a physician's office or outpatient facility) 50%
Laboratory procedures $40
Diagnostic imaging (including x-ray) services $50
CT, SPECT, MRI, MUGA and PET 50%
Rehabilitation and habilitation therapy $50
Chemotherapy $0
Radiation therapy $0
Telehealth services through Teladoc■ $0

▲*Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

■*Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Teladoc consultations provide primary care services by telephone or secure online video. Teladoc physicians may be used when your physician's office is closed or you need quick access to a physician. Teladoc consultation services may be obtained by calling 1-800-TELADOC (800-835-2362) or visiting www.teladoc.com/hn. Before Teladoc services may be accessed, you must complete a Medical History Disclosure (MHD) form, which can be completed online at Teladoc's website at no charge or printed, completed and mailed or faxed to Teladoc.*

Preventive Care

Preventive care services $0

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&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, 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, annual preventive physical examinations, 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 (as prescribed by your physician) will be covered for each pregnancy at no cost to the member. You can find out how to obtain a breast pump by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Prenatal, postnatal and newborn care that are preventive care are covered in full. If other non-preventive services are received during the same office visit, the office visit copayment will apply for the non-preventive services.

Outpatient Facility Services

Outpatient facility services (other than surgery – performed in a hospital)	50%
Outpatient facility services (other than surgery - performed in an outpatient surgery center)	40%
Outpatient surgery (surgery performed in a hospital only)	50%
Outpatient surgery (surgery performed in an outpatient surgery center)	40%

Outpatient care for infertility is described below in the "Infertility Services" section.

Hospitalization Services

Semi-private hospital room or special care unit with ancillary services, including maternity care (unlimited days)	50%
Skilled nursing facility stay	$25 per day
Physician visit to hospital or skilled nursing facility	50%

The above inpatient hospitalization copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services for the newborn patient will apply.

Inpatient care for infertility is described below in the "Infertility Services" section.

Emergency Health Coverage

Emergency room (facility charges)	50%
Emergency room Physician	50%
Urgent care center (professional and facility charges)	$70

Copayments for emergency room visit will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

Ambulance Services

Ground ambulance	50%
Air ambulance	50%

Prescription Drug Coverage

Please refer to the "Prescription Drug Program" section of this SB/DF for applicable definitions, benefit descriptions and limitations.

Deductible

Prescription drug deductible (per member/family, per calendar year)..... $500 Member/$1,000 Family

The prescription drug deductible required for drugs (per member, per calendar year) must be paid for prescription drug covered services before Health Net begins to pay.

Retail Participating Pharmacy (up to a 30-day supply)

Tier 1 drugs	$20 (prescription drug deductible waived)
Tier 2 drugs	50% (up to a maximum of $250 per prescription)
Tier 3 drugs	50% (up to a maximum of $250 per prescription)
Tier 4 drugs (specialty drugs)	50% (up to a maximum of $250 per prescription after prescription drug deductible)
Preventive drugs, and women's contraceptives*◆	$0 (prescription drug deductible waived)

Mail-order Program (a 90-day supply of maintenance drugs)s

Tier 1 drugs	$40 (prescription drug deductible waived)
Tier 2 drugs	50% (up to a maximum of $750 per prescription)
Tier 3 drugs	50% (up to a maximum of $750 per prescription)
Preventive drugs, and women's contraceptives*◆	$0 (prescription drug deductible waived)

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

Regardless of prescription drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover brand name drugs, including specialty drugs that have generic equivalents only when the brand name drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered brand name drugs are subject to the applicable copayment for Tier 2, Tier 3 or Tier 4 (specialty drugs) prescription drugs.

A physician must obtain Health Net's prior authorization for coverage of brand name drugs that have generic equivalents.

Percentage copayments will be based on Health Net's contracted pharmacy rate.

If the pharmacy's or the mail order administrator's retail price is less than the applicable copayment, then you will pay the pharmacy's or the mail order administrator's retail price. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

**Preventive drugs, including smoking cessation drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member, and are not subject to the deductible. Covered preventive drugs included prescribed over-the-counter drugs and prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs. 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 drug is medically necessary and the physician obtains pre-approval from Health Net, then the brand name drug will be dispensed at no charge.*

This plan uses the Essential Rx Drug List. For a copy of the Essential Rx Drug List, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

The Health Net Essential Rx Drug List (the 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. The List also shows which drugs are Tier 1, Tier 2, Tier 3 or Tier 4, so you know which copayment applies to the covered drug. Tier 4 (Specialty Drugs) are identified in the Essential Rx Drug List with "SP." Drugs that are not on the List (that are not excluded or limited from coverage) are also covered (as a coverage exception when authorized by Health Net) at the Tier 3 or Tier 4 drug copayment. Refer to "What's Covered" under the "Prescription Drug Program" section later in this SB/DF for more information about drugs that are covered under each drug tier.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed 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. Routine requests from physicians are processed in a timely fashion, not to exceed 72 hours, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	50%
Orthotics (such as bracing, supports and casts)	50%
Diabetic equipment*	50%
Diabetic footwear	50%
Prostheses (including ostomy and urological supplies)	50%

**See also the "Prescription Drug Program" section of this SB/DF for diabetic supplies benefit information. Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and insulin syringes.*

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the protheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

Mental Disorders and Chemical Dependency Benefits

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

Outpatient office visit/professional consultation*■ $50
Outpatient group therapy session $25
Outpatient services other than an office visit/professional consultation▲ $0
Participating Mental Health Professional Visit to a Member's home♦ $50
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center 50%
Inpatient services (including detoxification) at a Hospital, Behavioral Health Facility or Residential Treatment Center 50%

** If two or more Members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

■ Services include psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring.

▲ Services include psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment, partial hospitalization and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day.

♦ Visits to member's home are at the discretion of the Participating Mental Health Professional in accordance with rules and criteria established by the administrator.

Home Health Services

Home health services (copayment required for each visit) $50
Calendar year maximum ..... *100 visits*

Other Services

Blood or blood products, except for drugs used to treat hemophilia, including blood factors *..... $0
Renal dialysis $0
Hospice services $0

**Drugs for the treatment of hemophilia, including blood factors, are considered self-injectable drugs and covered as a Tier 4 drug (specialty drug) under the Prescription Drug benefit.*

Infertility Services

Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) ..... Not covered

Acupuncture Services

☐ *Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).*

Office visits.....$10

Pediatric Vision Care

☐ *Pediatric vision benefits are administered by Envolve Vision, Inc. Refer to the "Pediatric Vision Care Program" section later in this SB/DF for the benefit information which includes the Eyewear Schedule.*

Pediatric Dental

☐ *Pediatric dental benefits are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Refer to the "Pediatric Dental Program" section later in this SB/DF for the benefit information which includes the Dental Schedule. See the Evidence of Coverage for additional details.*

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- 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.
- Artificial insemination;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain.
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary;
- Chiropractic services, except as provided by ASH Plans as shown in the "Schedule of Benefits and Coverage" section of this SB/DF;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Except for podiatric devices to prevent or treat diabetes-related complications, corrective footwear is not covered unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services for members age 19 and over. However, Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use, except certain disposable ostomy or urological supplies. See the EOC for additional information;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you Have a Disagreement with our Plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Immunizations and injections for foreign travel/occupational purposes;
- Infertility services and supplies;
- Non-eligible institutions. 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 EOC. Any institution that is not licensed to provide medical services and supplies regardless of how it is designated, is not an eligible institution;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;

- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes or peripheral vascular disease;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net, the Behavioral Health Administrator or the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity. Certain services may be covered as preventive care services as described in the plan's EOC.
- Teladoc consultation services 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.
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The EOC, which you will receive if you enroll in this plan, will contain the full list. Notwithstanding any exclusions or limitations described in the EOC, all medically necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.

Benefits and Coverage

WHAT YOU PAY FOR SERVICES

The "Schedule of Benefits and Coverage" section explains your coverage and payment for services. Please take a moment to look it over.

TIMELY ACCESS TO CARE

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

You may contact Health Net at the number shown on y the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the plan's EOC or contact the Health Net Customer Contact Center at the phone number on the back cover.

Please see the "Notice of Language Services" section for information regarding the availability of no cost interpreter services.

SPECIAL ENROLLMENT RIGHTS IF YOU LOSE ELIGIBILITY FROM A MEDI-CAL PLAN

If you become ineligible and lose coverage under a Medi-Cal plan, you are eligible for a special enrollment period in which you and your dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the Federal Newborns' and Mothers' Health Protection Act of 1996 and Women's Health and Cancer Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 60th day of the child's life. If the child is not enrolled within 60 days of the child's birth:

- Coverage will end the 31st day after birth; and
- You will have to pay your physician group for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or to the nearest emergency facility or by calling **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All air and ground ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

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

Emergency Care *includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the member or unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.*

All air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

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:*

- *Placing the patient's health in serious jeopardy.*
- *Serious impairment to bodily functions.*
- *Serious dysfunction of any bodily organ or part.*

Emergency Psychiatric Medical Condition *means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:*

- *An immediate danger to himself or herself or to others.*
- *Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.*

Urgently needed care *includes otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.*

MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your Health Net plan (unless specifically excluded under the plan). All covered services or supplies are listed in the plan's EOC; any other services or supplies are not covered.

SECOND OPINIONS

You have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, call the Customer Contact Center at the phone number on the back cover.

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's EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

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 (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease

or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. 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

Once you become a Health Net member, Health Net uses and discloses a member's protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in the plan's EOC, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

** Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

TECHNOLOGY ASSESSMENT

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 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 *Evidence of Coverage* for additional details.

Utilization Management

Utilization management is an important component of health care management. Through the processes of pre-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. These processes help to maintain Health Net's high quality medical management standards.

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, 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 pre-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, their physicians and community resources.

If you would like additional information regarding Health Net’s utilization management process, please call the Health Net Customer Contact Center at the phone number on the back cover.

Payment of Fees and Charges

YOUR COPAYMENT AND DEDUCTIBLES

The "Schedule of Benefits and Coverage" section explains your coverage and payment for services. Please take a moment to look it over.

PREPAYMENT FEES

Your employer will pay Health Net your monthly subscription charges for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called copayments, which are described in the "Schedule of Benefits and Coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

When the total amount of copayments you pay equals the out-of-pocket maximum shown in the "Schedule of Benefits and Coverage" section, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your physician group.

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the "Schedule of Benefits and Coverage" section. For further information please refer to the plan's EOC.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive health care services without the required referral or authorization from your PCP or physician group (medical), or the Behavioral Health Administrator (mental disorder and chemical dependency), you are responsible for the cost of these services.

Remember, this plan only covers services that are provided or authorized by a PCP or physician group or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the Health Net HMO Directory for a full listing of Health Net-contracted physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by or through your physician group (medical), or the Behavioral Health Administrator (mental disorder and chemical dependency) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive emergency services not provided or directed by your physician group, you may have to pay at the time you receive service. To be reimbursed for these charges, you should get a complete statement of the services received and, if possible, a copy of the emergency room report.

Please call the Health Net Customer Contact Center at the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or directly to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

How to file a claim:

For medical services*, please send a completed claim form within one year of the date of service to:*

Health Net Commercial Claims
P.O. Box 9040

Farmington, MO 63640-9040

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain the claim form.

***For outpatient prescription drugs,** please send a completed prescription drug claim form to:*

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain a prescription drug claim form.

***For approved acupuncture services**, please send your completed claim form within one year of the date of service to:*

American Specialty Health Plans of California, Inc.
Attention: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

***For mental disorders or chemical dependency emergency services or for services authorized by** MHN Services, you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN Services within one year of the date of service at the address listed on the claim form or to MHN Services at:*

MHN Services
P.O. Box 14621
Lexington, KY 40512-4621

*Please call MHN Services at **1-800-444-4281** to obtain a claim form.*

Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

PROVIDER REFERRAL AND REIMBURSEMENT DISCLOSURE

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Customer Contact Center at the phone number on the back cover. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

Health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you chose at enrollment; or
- A nearby Health Net-contracted hospital, if hospitalization is required.

Many Health Net contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your *Health Net HMO Directory.*

PHYSICIAN GROUP TRANSFERS

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Simply contact Health Net to have your transfer effective by the 1st of the following month.

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please call the Health Net Customer Contact Center at the phone number on the back cover of this booklet for more information.)

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a physician group or other provider ends, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that end their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has ended, subject to applicable copayments 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.

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

- The following conditions are eligible for continuation of care:
- An acute condition;
- A serious chronic condition not to exceed twelve months;

- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age, not to exceed twelve months);
- A terminal illness (through the duration of the terminal illness);
- A surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for a new enrollee) as part of a documented course of treatment.

In addition, you may request continued care from a provider, including a hospital, if you have been enrolled in another Health Net HMO plan that included a larger network than this plan, Health Net will offer the same scope of continuity of care for completion of services, regardless of whether you had the opportunity to retain your current provider by selecting either:

- a Health Net product with an out of network benefit;
- a different Health Net HMO network product that included your current provider; or
- another health plan or carrier product.

To request continued care, you will need to complete a Continuity of Care Assistance Request form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care Assistance Request form or of our continuity of care policy, please call the Customer Contact Center at the phone number on the back cover.

Renewing, Continuing or Ending Coverage

RENEWAL PROVISIONS

The contract between Health Net and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

SMALL EMPLOYER CAL-COBRA COVERAGE

When the group is a small employer (as defined in the *Evidence of Coverage*), state law provides that members who enroll in this plan and later lose eligibility may be entitled to continuation of group coverage. More information regarding eligibility for this coverage is provided in your *Evidence of Coverage*.

INDIVIDUAL CONTINUATION OF BENEFITS

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage.

- **Cal-COBRA Continuation Coverage**: If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not

entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

TERMINATION OF BENEFITS

The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan's EOC.

Termination for Nonpayment of Subscription Charges

Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

Termination for Loss of Eligibility

Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this plan and Health Net ends;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Termination for Cause

Coverage under this Health Net plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a dependent;
- Presenting an invalid prescription or physician order;
- Misusing a Health Net Member I.D. Card (or letting someone else use it); or
- Failing to notify us of changes in family status that may affect your eligibility or benefits.

If we terminate your membership for cause, you will not be allowed to enroll in a Health Net health plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

How to Appeal Your Termination

You have a right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "If You Have a Disagreement with our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage

until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "If You Have a Disagreement with our Plan" section.

If the person involved in any of the above activities is the enrolled employee, coverage under this plan will end as well for any covered dependents.

If You Have a Disagreement with our Plan

The provisions referenced under this title as described below are applicable to services and supplies covered under this SB/DF. The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover and use the 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, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

MEMBER GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.

 How to file a grievance or appeal:

You may call the Customer Contact Center at the phone number on the back cover or submit a Member Grievance Form through the Health Net website at www.healthnet.com:

You may also write to: *Health Net of California*

P.O. Box 10348
Van Nuys, CA 91410-0348

Please include all the information from your Health Net identification card as well as details of your concern or problem.

Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from the receipt of all the required information. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies your 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, you can request an independent medical review of Health Net's decision from the Department of Managed Health Care if you meet the eligibility criteria set out in the plan's EOC.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional Plan Benefit Information

The following plan benefits show benefits available with your plan. For a more complete description of copayments, and exclusions and limitations of service, please see the plan's EOC.

Behavioral Health Services

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services through a personalized, confidential and affordable mental disorder and chemical dependency care program.

Contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a participating mental health professional, a participating independent physician or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Behavioral Health Administrator in order to be covered.

Please refer to the plan's EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form If you would like more information on how to request continued care, or to request a copy of the Continuity of Care Assistance Request Form or of our continuity of care policy, please call the Customer Contact Center at the phone number on the back cover.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

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

SEVERE MENTAL ILLNESS

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

CONTINUATION OF TREATMENT

If you are in treatment for a mental disorder or chemical dependency problem, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

WHAT'S COVERED

Please refer to the "Schedule of Benefits and Coverage" section of this SB/DF for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- *Services or supplies for the treatment of mental disorder and chemical dependency are subject to the plan's general exclusions and limitations. Please refer to the "Limits of Coverage" section of this SB/DF for a list of what's not covered under this plan.*

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Prescription Drug Program

Health Net contracts with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions by Mail Drug Program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Customer Contact Center at the phone number on the back cover.

Tier 4 (specialty drugs) and Schedule II narcotic drugs (*which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order.*

THE HEALTH NET ESSENTIAL RX DRUG LIST

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

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

The Essential Rx Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Essential Rx Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

To obtain a copy of Health Net's most current Essential Rx Drug List, please visit our web site at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

 How to request prior authorization:

Requests for prior authorization may be submitted electronically or by telephone or facsimile. Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan's EOC for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover**;**
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
- Write to: Health Net Customer Contact Center
  P.O. Box 10348
  Van Nuys, CA 91410-0348

WHAT'S COVERED

 Please refer to the "Schedule of Benefits and Coverage" section of this SB/DF for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs - Drugs listed as Tier 1 on the Essential Rx Drug List that are not excluded from coverage (include most generic drugs and some low cost preferred brand name drugs listed on the Essential Rx Drug List);
- Tier 2 drugs – Drugs listed as Tier 2on the Essential Rx Drug List that are not excluded from coverage (include non-preferred generic, preferred brand name drugs, peak flow meters, in-

haler spacers, insulin and diabetic supplies when listed in the Essential Rx Drug List and certain brand name drugs with a generic equivalent when listed in the Essential Rx Drug List); and

- Tier 3 drugs - Drugs listed on the Essential Rx Drug List as Tier 3 (include non-preferred brand name drugs, brand name drugs with a generic equivalent when medically necessary, drugs listed as Tier 3 Drugs, drugs indicated as "NF", if approved, or drugs not listed in the Essential Rx Drug List)
- Tier 4 (specialty drugs) - provided through a Specialty Pharmacy Vendor (include specialty, self-administered injectable drugs (excluding insulin); high-cost drugs used to treat complex or chronic conditions when listed in the Essential Rx Drug List; and specialty drugs that are not listed on the Essential Rx Drug List and that are covered as an exception)
- Preventive drugs and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- If a prescription drug deductible applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies,nd preventive drugsand women's contraceptives are not subject to the deductible. After the deductible is met, the copayment amounts will apply.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Essential Rx Drug List. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit. For information about copayments required for these benefits, please see the "Schedule of Benefits and Coverage" section of this SB/DF.
- Covered preventive drugs include prescribed over-the-counter drugs and prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's EOC for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to

dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for up to a 30-day period. For more information about diabetic equipment and supplies, please see “Endnotes” in the "Schedule of Benefits and Coverage" section of this SB/DF.

- Self-injectable drugs (other than insulin), including drugs for the treatment of hemophilia, and needles and syringes used with these self-injectable drugs are included under Tier 4 (specialty drugs), which are subject to Prior Authorization and must be obtained through Health Net’s contracted specialty pharmacy vendor. Your PCP or treating Physician will coordinate the authorization and upon approval the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor may contact you directly to coordinate the delivery of your medications.
- Tier 4 (specialty drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring training or clinical monitoring, be manufactured using biotechnology, or have high cost as established by Covered California. Tier 4 (specialty drugs) are identified in the Essential Rx Drug List with “SP”, require Prior Authorization from Health Net and may be required to be dispensed through the Specialty Pharmacy Vendor to be covered. Tier 4 (specialty drugs) are not available through mail order.

WHAT’S NOT COVERED (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’s EOC for more information.

- Allergy serum is covered as a medical benefit. See “allergy serum” benefit in the “Schedule of Benefits and Coverage” for details;
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity or when you meet Health Net prior authorization coverage requirements. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician’s staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period. Sexual dysfunction drugs are not available through the mail order program;
- 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 independent medical review. See "If You Have a Disagreement with our Plan" section of this SB/DF for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;

- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. 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 A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered;
- Prescription drugs filled at pharmacies that are not in the Health Net pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member 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;
- Once You have taken possession of medications, replacement of lost, stolen or damaged medications is not covered.
- 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 as described in the plan's EOC; and
- Drugs prescribed for a condition or treatment not covered by this plan, are not covered. However, the plan does cover drugs for medical conditions that result from non-routine complications of a non-covered service.

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Acupuncture Care Program

Acupuncture Services, typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, are provided by Health Net. Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted acupuncturist.

With this program, you are free to obtain care by self-referring to a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*. All covered services require pre-approval by ASH Plans except for:

- 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.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the treatment plan include not only the approved services but also a re-examination in each subsequent office visit, if deemed necessary by the contracted acupuncturist, without additional approval by ASH Plans.

DEFINITION OF ACUPUNCTURE COVERED SERVICES

Medically necessary services provided by a contracted acupuncturist (or a non-contracted acupuncturist, when a referral is approved by ASH Plans) for the following injuries, illnesses, diseases, functional disorders or conditions, when determined medically necessary.

WHAT'S NOT COVERED (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 EOC for more information.

- Diagnostic scanning, MRI, CAT scans or thermography;
- X-rays, laboratory tests, and x-ray second opinions;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, self-help items or services, or physical exercise training;
- Physical therapy services classified as experimental or investigational;
- Experimental or investigational acupuncture services. Only acupuncture services that are non-investigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Charges for hospital confinement and related services;
- Charges for anesthesia; and
- Treatment or services not authorized by ASH Plans or not delivered by a contracted acupuncturist when authorization is required; treatment not delivered by a contracted acupuncturist (except upon referral to a non-contracted acupuncturist approved by ASH Plans).
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered.

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Pediatric Vision Care Program

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

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

Professional Services	***Copayment***
Routine eye examination with dilation, as Medically Necessary	$0

Limitation:

In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every 12 months.

Materials (including frames and lenses) ***Copayment***

Provider selected Frames (one every 12 months) $0

Standard Plastic Eyeglass Lenses (one pair every 12 months) $0

- Single vision, bifocal, trifocal, lenticular
- Glass or plastic

Optional Lenses and Treatments including:.....$0

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate –
- Photochromic / Transitions Plastic
- Standard Anti-Reflective Coating
- Polarized
- Standard Progressive Lens
- Hi-Index Lenses
- Blended segment Lenses
- Intermediate vision Lenses
- Select or ultra progressive lenses

Premium Progressive Lenses $0

Provider selected Contact Lenses (In lieu of eyeglass lenses).....$0

- Extended Wear Disposables: Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
- Daily Wear/Disposables: Up to 3 month supply of daily disposables, single vision spherical contact lenses
- Conventional: 1 pair from selection of provider designated contact lenses
- Medically Necessary*

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

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

Medically Necessary Contact Lenses:
Coverage of Medically Necessary contact lenses is subject to Medical Necessity and all applicable exclusions and limitations.

WHAT'S NOT COVERED (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 EOC for more information.

In addition to the limitations described above, the plan does not cover the following:

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

LIABILITY FOR PAYMENT

If you go to a care provider not affiliated with Health Net, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Pediatric Dental Program

All of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. Refer to the "Pediatric Dental Care Program Exclusions and Limitations" for limitations on covered pediatric dental services.

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

Subscribers must select a single Primary Dentist from the Participating Dentist Directory for their area for themselves and their enrolled Family Members (i.e., enrolled Family Members must use the same Primary Dentist). Call the Customer Contact Center at the number on your Health Net ID Card for a listing of participating dental providers. Each Member's Primary Dentist is responsible for the provision, direction and coordination of the Member's complete dental care. Members are required to select a Primary Dentist at the time of enrollment. If you do not make this selection and notify Health Net, Health Net will assign a Primary Dentist within close proximity to the Subscriber's primary residence. The assignment will be made within 31 days from the Member's commencement of coverage or 31 days after receiving complete enrollment information, whichever is later.

When you receive Benefits from your selected Primary Dentist you only pay the applicable Copayment amount noted below. You do not need to submit a claim. Health Net arranges for the provision of dental services by contracting with Participating Dentists to serve you in an organized and cost-effective manner.

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

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net dental ID Card or your insurance broker. To fully understand your coverage, you may wish to carefully review the Evidence of Coverage document.

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

Code	Service	Member Copayment
	Diagnostic	
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) up to six times in a 3 month period and up to a maximum of 12 in a 12 month period	No Charge

Code	Service	Member Copay-ment
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays Intraoral - complete series (including bitewings) limited to once per provider every 36 months	No Charge
D0220	X-rays Intraoral - periapical first film limited to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral-periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.	No Charge
D0230	X-rays Intraoral - periapical each additional film limited to a maximum of 20 periapicals in a 12 month period	No Charge
D0240	X-rays Intraoral - occlusal film limited to 2 in a 6 month period	No Charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector - first film	No Charge
D0251	Extraoral posterior dental radiographic image	No Charge
D0270	X-rays Bitewing - single film limited to once per date of service	No Charge
D0272	X-rays Bitewings - two films limited to once every 6 months	No Charge
D0273	X-rays Bitewings - three films	No Charge
D0274	X-rays Bitewings - four films– limited to 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

Code	Service	Member Copay-ment
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0351	3D photographic image	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Office visit fee - per visit (Unspecified diagnostic procedure, by report)	No Charge
	Preventive	
D1110	Prophylaxis - adult limited to once in a 12 month period	No Charge
D1120	Prophylaxis - child limited to once in a 6 month period	No Charge
D1206	Topical fluoride varnish limited to once in a 6 month period	No Charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6 month period	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	Interim caries arresting medicament application - per tooth	No Charge

Code	Service	Member Copay-ment
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
D1550	Re-cementation or re-bond of space maintainer	No Charge
D1555	Removal of fixed space maintainer	No Charge
D1575	Distal shoe space maintainer - fixed - unilateral	No Charge
	Restorative (Basic Services)	
D2140	Amalgam - one surface, primary limited to once in a 12 month period	$25
D2140	Amalgam - one surface, permanent limited to once in a 36 month period	$25
D2150	Amalgam - two surfaces, primary limited to once in a 12 month period	$30
D2150	Amalgam - two surfaces, permanent limited to once in a 36 month period	$30
D2160	Amalgam - three surfaces, primary limited to once in a 12 month period	$40
D2160	Amalgam - three surfaces, permanent limited to once in a 36 month period	$40
D2161	Amalgam - four or more surfaces, primary limited to once in a 12 month period	$45
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36 month period	$45
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12 month period	$30
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36 month period	$30
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12 month period	$45

Code	Service	Member Copayment
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36 month period	$45
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12 month period	$55
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36 month period	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) primary limited to once in a 12 month period	$60
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) permanent limited to once in a 36 month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12 month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36 month period	$50
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12 month period	$30
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36 month period	$30
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12 month period	$40
D2392	Resin-based composite – two surfaces, posterior; permanent limited to once in a 36 month period	$40
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12 month period	$50
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36 month period	$50
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12 month period	$70
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36 month period	$70
D2710	Crown - Resin-based composite (indirect) limited to once in a 5 year period	$140
D2712	Crown – ¾ resin-based composite (indirect) limited to once in a 5 year period	$190

Code	Service	Member Copayment
D2721	Crown - Resin with predominantly base metal limited to once in a 5 year period	$300
D2740	Crown - porcelain/ceramic substrate limited to once in a 5 year period	$300
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5 year period	$310
D2791	Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12 month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12 month period	$95
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12 month period	$65
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36 month period	$75
D2932	Prefabricated Resin Crown, primary limited to once in a 12 month period	$75
D2932	Prefabricated Resin Crown, permanent limited to once in a 36 month period	$75
D2933	Prefabricated Stainless steel crown with resin window, primary limited to one in a 12 month period	$80
D2933	Prefabricated Stainless steel crown with resin window, permanent limited to once in a 36 month period	$80
D2940	Protective restoration limited to once per tooth in a 12 month period	$25
D2941	Interim therapeutic restoration - primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45

Code	Service	Member Copay-ment
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention - per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post - same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to construct new crown under existing partial dental framework	$35
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.	$50
D2999	Unspecified restorative procedure, by report	$40
	Endodontics (Major Services)	
D3110	Pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap - indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3310	Endodontic (Root canal) therapy, Anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195

Code	Service	Member Copay-ment
D3320	Endodontic (Root canal) therapy, Bicuspid (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (Root canal) therapy, Molar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy - anterior	$240
D3347	Retreatment of previous root canal therapy - bicuspid	$295
D3348	Retreatment of previous root canal therapy - molar	$365
D3351	Apexification/recalcification - initial visit (apical clo-sure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	$85
D3352	Apexification/recalcification - interim medication replace-ment only following D3351. Limited to once per perma-nent tooth	$45
D3410	Apicoectomy - anterior	$240
D3421	Apicoectomy - bicuspid (first root)	$250
D3425	Apicoectomy - molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3427	Periradicular surgery without apicoectomy	$160
D3430	Retrograde filling - per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
	Periodontics (Major Services)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$50
D4249	Clinical crown lengthening - hard tissue	$165

Code	Service	Member Copay-ment
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth spaces per quadrant - once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant– once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$220
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist) Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
	Prosthodontics, removable (Major Services)	
D5110	Complete denture - maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5120	Complete denture - mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5130	Immediate denture - maxillary	$300
D5140	Immediate denture - mandibular	$300

Code	Service	Member Copayment
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$335
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$275
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$275
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12 month period	$20
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12 month period	$20
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12 month period	$20
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12 month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth - complete denture (each tooth) limited to a maximum of four, per arch, per date of service; twice per arch in a 12 month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40

Code	Service	Member Copay-ment
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$50
D5640	Replace broken teeth - per tooth - limited to maximum of four, per arch, per date of service; twice per arch in a 12 month period	$35
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12 month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12 month period	$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12 month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12 month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12 month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12 month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12 month period	$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12 month period	$80
D5850	Tissue conditioning, maxillary limited to twice per pros-thesis in a 36 month period	$30

Code	Service	Member Copay-ment
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.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture - complete maxillary	$300
D5864	Overdenture - partial maxillary	$300
D5865	Overdenture - complete mandibular	$300
D5866	Overdenture - partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
	Maxillofacial Prosthetics (Major Services)	
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350

Code	Service	Member Copay-ment
D5933	Obturator prosthesis, modification limited to twice in a 12 month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12 month period	$145
D5960	Speech aid prosthesis, modification limited to twice in a 12 month period	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
	Implant Services (Major Services)	
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350

Code	Service	Member Copayment
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335

Code	Service	Member Copayment
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330
D6077	Implants supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6085	Provisional implant crown	$300
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6096	Removal of broken implant retaining screw	$60
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350

Code	Service	Member Copay-ment
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
	Prosthodontics, fixed (Major Services)	
D6211	Pontic - cast predominantly base metal limited to once in a 5 year period	$300
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6245	Pontic - porcelain/ceramic limited to once in a 5 year period	$300
D6251	Pontic - resin with predominantly base metal limited to once in a 5 year period	$300
D6721	Retainer Crown - resin predominantly base metal – denture limited to once in a 5 year period	$300
D6740	Retainer Crown - porcelain/ceramic limited to once in a 5 year period	$300
D6751	Retainer Crown -porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6781	Retainer Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D6783	Retainer Crown ¾ porcelain/ceramic limited to once in a 5 year period	$300
D6791	Retainer Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D6930	Recement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
	Oral Maxillofacial Prosthetics (Major Services)	
D7111	Extraction, coronal remnants - deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65

Code	Service	Member Copay-ment
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth - soft tissue	$95
D7230	Removal of impacted tooth - partially bony	$145
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. A Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$50

Code	Service	Member Copay-ment
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$65
D7340	Vestibuloplasty - ridge extension (secondary epithelializa-tion) limited to once in a 5 year period per arch	$350
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attach-ment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor - lesion di-ameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion di-ameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial ex-ostosis only	$140
D7472	Removal of torus palatinus limited to once in a patient’s lifetime	$145

Code	Service	Member Copayment
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250
D7630	Mandible - open reduction (teeth immobilized, if present)	$350
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch - open reduction	$350
D7660	Malar and/or zygomatic arch - closed reduction	$350
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170
D7671	Alveolus - open reduction, may include stabilization of teeth	$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla - open reduction	$110
D7720	Maxilla - closed reduction	$180

Code	Service	Member Copay-ment
D7730	Mandible - open reduction	$350
D7740	Mandible - closed reduction	$290
D7750	Malar and/or zygomatic arch - open reduction	$220
D7760	Malar and/or zygomatic arch - closed reduction	$350
D7770	Alveolus - open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy - diagnosis, with or without biopsy	$350
D7873	Arthroscopy - lavage and lysis of adhesions	$350
D7874	Arthroscopy - disc repositioning and stabilization	$350
D7875	Arthroscopy - synovectomy	$350
D7876	Arthroscopy - discectomy	$350
D7877	Arthroscopy - debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35

Code	Service	Member Copay-ment
D7911	Complicated suture - up to 5 cm	$55
D7912	Complicated suture - greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty - for orthognathic deformities	$160
D7941	Osteotomy - mandibular rami	$350
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy - segmented or subapical	$275
D7945	Osteotomy - body of mandible	$350
D7946	LeFort I (maxilla - total)	$350
D7947	LeFort I (maxilla - segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350
D7949	LeFort II or LeFort III - with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure not incidental to another procedure limited to once per arch per date of service	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
D7979	Non-surgical Sialolithotomy	$155
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215

Code	Service	Member Copay-ment
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft - mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
	Orthodontics	
	Medically Necessary Banded Case (The copayment applies to a Member's course of treatment as long as that Member remains enrolled in this plan.)	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Recement or re-bond fixed retainer	
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental Pain - minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20

Code	Service	Member Copay-ment
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9222	Deep sedation/general anesthesia - first 15 minutes	$45
D9223	Deep sedation/general anesthesia– each 15 minute incre-ment	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia– each 15 minute increment	$60
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	$0
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a bene-fit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12 month period; permanent teeth only	$20
D9930	Treatment of complications – post surgery, unusual cir-cumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12 month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12 month period per quadrant	$45

Code	Service	Member Copayment
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)	$210
D9999	Unspecified adjunctive procedure, by report	$0

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

Orthodontic Benefits

This dental plan covers orthodontic benefits as described above. Extractions and initial diagnostic x-rays are not included in these fees. Orthodontic treatment must be provided by a Participating Dentist.

Referrals to Specialists for Orthodontic Care

Each Member's Primary Dentist is responsible for the direction and coordination of the Member's complete dental care for Benefits. If your Primary Dentist recommends orthodontic care and you wish to receive Benefits for such care under this dental plan, Health Net's Customer Contact Center will assist you in selecting a Participating Orthodontist from the Participating Orthodontist Directory.

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

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

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

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

Pediatric Dental Care Program Exclusions and Limitations

Services or supplies excluded under pediatric dental services may be covered under the medical benefits portion of your plan. Consult the plan's EOC for more information.

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this plan's schedule of benefits:

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or** b) is inconsistent with generally accepted standards for dentistry.
- Implant Services (D6000-D6199): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.

- Medically Necessary Orthodontia (D8000-D8999): Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
  - Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
  - All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
  - Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
  - The automatic qualifying conditions are:
    - cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - a crossbite of individual anterior teeth causing destruction of soft tissue,
    - an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    - a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

  If a member does not score 26 or above nor meets one of the six automatic qualifying conditions, he/she may be eligible under the Early and Periodic Screening, Diagnosis and Treatment – Supplemental Services (EPSDT-SS) exception if medically necessity is documented.

- Adjunctive Services (D9000-D9999); Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;
  - Palliative treatment (relief of pain)
  - Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.
  - House/extended care facility calls, once per member per date of service.
  - One hospital or ambulatory surgical center call per day per provider per member.
  - Anesthesia for members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require Prior Authorization.
  - Occlusal guards when medically necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition.
- The following services, if in the opinion of the attending dentist or Health Net are not Medically Necessary, will not be covered:
  - Temporomandibular joint treatment (aka "TMJ").
  - Elective Dentistry and cosmetic dentistry.

- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.
- Prescription Medications.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Any procedure of implantation.
- Any Experimental procedure.
- General anesthesia or Intravenous/Conscious sedation, except as specified in the medical benefits section.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member's responsibility. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a Covered Service.
- Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist. Pediatric dental services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

Notice of Language Services

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, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 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，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（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, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (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, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (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。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (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 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bąąh 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' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (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، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (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, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (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, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (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, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (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, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

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

FLY017549EH00 (12/17)

Nondiscrimination Notice

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

HEALTH NET:

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

If you need these services, contact Health Net's Customer Contact Center at:

Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)

Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)

Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

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

You can also file a grievance by mail, fax or email at:

Health Net of California, Inc. Appeals & Grievances
P.O. Box 10348,
Van Nuys, CA 91410-0348
Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com(Applicants)

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

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

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

FLY028964EP00 (3/19)

CONTACT US

For more information, please contact us at:

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

Small Business Group:
1-800-361-3366 (English) TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

SBID: 92549