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

Small Business Group
CommunityCare HMO Gold $5 • Plan C9N

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 at1-800-361-3366,

Or write to: Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

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."

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE HEALTH NET HMO COMMUNITYCARE NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM COMMUNITYCARE NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

Except for Emergency Care, benefits for Physician and Hospital services under this **Health Net HMO CommunityCare Network** ("CommunityCare Network") plan are only available when you live or work in the CommunityCare Network service area and use a CommunityCare Network Physician or Hospital. When you enroll in this CommunityCare Network plan, you may only use a Physician or Hospital who is in the CommunityCare Network and you must choose a CommunityCare Network Primary Care Physician. You may obtain ancillary, Pharmacy or Behavioral Health covered services and supplies from any Health Net Participating ancillary, Pharmacy or Behavioral Health Provider.

Obtaining Covered Services under the Health Net HMO CommunityCare Network Plan

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY	BEHAVIORAL HEALTH
AVAILABLE FROM	*Only Community Care Network Hospitals	*Only CommunityCare Network Physicians	All Health Net Contracting Ancillary Providers	All Health Net Participating Pharmacies	All Health Net Contracting Behavioral Health providers
*The benefits of this plan for Physician and Hospital services are only available for covered services received from a CommunityCare Network Physician or Hospital, except for (1) Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care; (2) referrals to non-CommunityCare Network providers are covered when the referral is issued by your CommunityCare Network Physician Group; and (3) covered services provided by a non-CommunityCare Network provider when authorized by Health Net. Please refer to the "Introduction to Health Net" section for more details on referrals and how to obtain Emergency Care.					

The CommunityCare Network service area and a list of its Physician and Hospital providers are shown in the Health Net *CommunityCare Network Provider Directory*, which is available online at our website www.healthnet.com. You can also call the Health Net Customer Contact Center at 1-800361-3366 to request provider information. The *CommunityCare Network Provider Directory* is different from other Health Net Provider Directories.

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

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

- Health Net
- Health Net Service Area
- Hospital
- Member Physician, Participating Physician Group, Primary Care Physician, Physician, participating provider, contracting Physician Groups and contracting Providers
- Network
- Provider Directory

If you have any questions about the CommunityCare Network Service Area, choosing your Community Care Network Primary Care Physician, how to access Specialist care or your benefits, please contact the Health Net Customer Contact Center at 1-800-361-3366.

Health Net CommunityCare Network Alternative Access Standards

This section pending resolution of CommunityCare Network Recertification filing.

The CommunityCare Network includes participating primary care and Specialist Physicians, and Hospitals in the CommunityCare service area. However, CommunityCare Members residing in the following zip codes will need to travel as indicated to access a participating PCP and/or receive non-emergency Hospital services.

16– 30 Miles

Los Angeles County: 90263 –Malibu (Hospital), **90264** – Malibu (Hospital), **90265** - Malibu (PCP and Hospital), **91301** – Agoura Hills (Hospital), **91310** – Castaic (Hospital), **91350** - Santa Clarita (Hospital), **91354** – Valencia (Hospital), **91355** – Valencia (Hospital), **91383** – Santa Clarita (Hospital), **91384** – Castaic (Hospital), **91390** – Santa Clarita (Hospital), **93535** – Lancaster (PCP and Hospital), **93536** – Lancaster (PCP), **93543** – Littlerock (Hospital), **93544** – Llano (Hospital), **93553** – Pearblossom (Hospital), **93563** – Valyermo (Hospital), **93591** – Palmdale (Hospital)

Orange County: 92607 – Laguna Niguel (Hospital), **92610** – Foothill Ranch (Hospital), **92624** – Capistrano Beach (Hospital), **92629** – Dana Point (Hospital), **92630** – Lake Forest (Hospital), **92651** – Laguna Beach (Hospital), **92653** – Laguna Beach (Hospital), **92656** – Aliso Viejo (Hospital), **92673** – San Clemente (Hospital), **92674** – San Clemente (Hospital), **92675** – San Juan Capistrano (Hospital), **92677** – Laguna Niguel (Hospital), **92678** – Trabuco Canyon (Hospital), **92679** – Trabuco Canyon (Hospital), **92688** – Rancho Santa Margarita (Hospital), **92690** – Mission Viejo (Hospital), **92691** – Mission Viejo (Hospital), **92692** – Mission Viejo (Hospital), **92693** – San Juan Capistrano (Hospital), **92694** – Ladera Ranch (Hospital)

Beyond 30 Miles

Los Angeles County: 93532 – Lake Hughes (Hospital: 37 miles), **93536** – Lancaster (Hospital: 35 miles)

Orange County: 92672 – San Clemente (Hospital: 31 miles)

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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 or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. 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 or gynecology, 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.

HMO SPECIALIST ACCESS

Health Net offers Rapid Access®, a service that makes it easy for you to quickly connect with a specialist in Health Net's network. Ask your group or check the *Health Net HMO Directory* to see if your physician group allows "self-referrals" or "direct referrals" to specialists within the same group. Self-referral allows you to contact a specialist directly for consultation and evaluation. Direct referral allows your doctor to refer you directly to a specialist without the need for physician group authorization. Information about your physician group's referral policies is also available to you on our web site 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 PLAN CONTRACT AND evidence of coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

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

Principal benefits and coverage matrix

Deductibles ..... $1,500 Member/$3,000 Family

For certain medical services and supplies under this plan, except as specifically noted below, a calendar-year deductible applies, which must be satisfied before these services and supplies are covered. You must pay an amount of covered expenses for these services equal to the Calendar Year Deductible shown above before the benefits are paid by your Plan.

Lifetime maximums ..... None

Out-of-Pocket maximum

One member $6,000

Family (two or more members) $12,000

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.

Visit to physician, physician assistant or nurse practitioner at a contracting physician group✧ ..... $5 (deductible waived)

Specialist consultations ▪ ..... $30 (deductible waived)

Visit to CVS MinuteClinic ◆ ..... $5 (deductible waived)

Prenatal care and preconception visits * ..... $5 (deductible waived)

Postnatal office visits * ..... $5 (deductible waived)

Normal delivery, cesarean section, newborn inpatient care 20%

Treatment of complications of pregnancy ..... See note below **

Surgeon or assistant surgeon services ▲	20%
Administration of anesthetics	20%
Laboratory procedures	$10 (deductible waived)
Diagnostic imaging (including x-ray) services	$10 (deductible waived)
CT, SPECT, MRI, MUGA and PET	$150
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$5 (deductible waived)
Habilitative therapy	$5 (deductible waived)
Organ and stem cell transplants (non-experimental and non-investigational)	$0
Chemotherapy	$0
Radiation therapy	$0
Primary care physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net✧	$5 (deductible waived)
Specialist visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	$30 (deductible waived)
Hearing examiniation for diagnosis and treatment	$5 (deductible waived)
Vision examination for diagnosis and treatment (for members age 19 and over) by an Optometrist***	$5 (deductible waived)
Vision examination for diagnosis and treatment (for members age 19 and over) by an Opthamologist***	$5 (deductible waived)

✧*The Primary Care Physician copayment applies after the first service under Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group or Primary Care Physician visit to Member's home, but not both, for non-preventive care.*

■*Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

◆*Specialist referrals following care at the CVS MinuteClinic must be obtained through the contracting physician group. Preventive care services through the CVS MinuteClinic are subject to the copayment shown below under "Preventive care."*

▲*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.*

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

***Applicable copayment requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit will apply.*

****See "Pediatric Vision Services (birth through age 18)" for details regarding pediatric vision care services for ages younger than 19.*

Preventive care

Preventive care services ..... $0 (deductible waived)

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&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 will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Allergy treatment and other injections (except for infertility injections)

Allergy testing ..... $30 (deductible waived)

Allergy injection services ..... $5 (deductible waived)

Allergy serum ..... $5 (deductible waived)

Immunizations -- To meet foreign travel or occupational requirements ..... Not covered

Injections (excluding infertility)

Injectable drugs administered by a physician (per dose) 30%

Self injectable drugs■ ..... 30%up to a maximum of $500 per script (deductible wavied)

■ *Self-injectable drugs (other than insulin) are considered Tier IV (Specialty Drugs), which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Please refer to the plan's EOC for additional information.*

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient facility services

Outpatient facility services (other than surgery) 20%

Outpatient surgery (surgery performed in a hospitalonly) 20%

Outpatient surgery (surgery performed in an outpatient surgery center) 20%

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) 20%

Skilled nursing facility stay ..... $25 per day
Physician visit to hospital or skilled nursing facility $0

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) $150
Emergency room Physician $0
Urgent care center (professional and facility charges) $75

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 $150
Air ambulance $150

Prescription drug coverage

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

Retail participating pharmacy (up to a 30-day supply)

Tier I drugs (most generic drugs and low cost brand name drugs listed on the Essential Rx Drug List) $5

Tier II drugs (non-preferred generic and preferred Brand Name Drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Essential Rx Drug List) ◆ $40

Tier III drugs (non-preferred Brand Name Drugs, drugs listed as Tier III Drugs or drugs not listed in the Essential Rx Drug List)◆ $60

Tier IV Drugs (Specialty Drugs) (typically provided through a Specialty Pharmacy Vendor) ..... 30% up to a maximum of $500 per script

Preventive drugs, including smoking cessation drugs, and women's contraceptives $0

Oral infertility drugs 50%

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

Tier I drugs (most generic drugs and low cost brand name drugs listed on the Essential Rx Drug List) $10

Tier II (non-preferred generic and preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List)◆ $100

Tier III drugs non-preferred Brand Name Drugs, drugs listed as Tier III Drugs or drugs not listed in the Essential Rx Drug List◆ $150

Preventive drugs, including smoking cessation drugs, and women's contraceptives* $0

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

For information about Health Net's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on the back cover.

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 II, Tier III or Tier IV (Specialty Drugs) prescription drugs.

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

** 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. 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.*

If a brand name drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand name drug. However, if a brand name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand name drug will be dispensed at no charge.

Tier IV (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 IV (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 IV (Specialty) Drugs are not available through mail order.

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

If the retail price is less than the applicable copayment, then you will pay the 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.

This plan uses the Essential Rx Drug List. 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 I, Tier II, Tier III or Tier IV, so you know which copayment applies to the covered drug. Drugs that are not on the List (that are not excluded or limited from coverage) are also covered at the Tier III or Tier IV drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed24 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. 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.

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) 20%

Orthotics (such as bracing, supports and casts) 20%

Diabetic Equipment (See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information.) 20%

Diabetic footwear..... 20%

Prostheses 20%

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Prostheses include coverage of ostomy and urological supplies.

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. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)*✧	$5 (deductible waived)
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, 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)	$0 (deductible waived)
Participating Mental Health Professional Visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with rules and criteria estblished by the administrator)✧	$5 (deductible waived)
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	20%

Other Mental Disorders

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting including individual and group therapy sessions, medication management and drug therapy monitoring)*✧	$5 (deductible waived)
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	$0 (deductible waived)
Participating Mental Health Professional Visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with rules and criteria estblished by the administrator) ✧	$5 (deductible waived)
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	20%

Chemical Dependency

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting including individual and group therapy sessions, medication management and drug therapy monitoring)✱✧	$5 (deductible waived)
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	$0 (deductible waived)
Participating Mental Health Professional Visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with rules and criteria estblished by the administrator)✧	$5 (deductible waived)
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	20%
Acute care detoxification at a Hospital, Behavioral Health Facility or Residential Treatment Center	20%

✱*Each group therapy session requires only one half of a private office visit copayment. If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

✧*The copayment applies after the first service under Outpatient office visit or Participating Mental Health Professional Visit to a Member's home, for non-preventive care.*

Home health services

Home health services (copayment required for each day home health visits occur)	$5 (deductible waived)
Calendar year maximum	*100 visits*

Other services

Sterilizations --Vasectomy	$150 (deductible waived)
Sterilizations --Tubal ligation	$0 (deductible waived)
Blood, blood plasma, blood derivatives and blood factors	$0
Renal dialysis	$0
Hospice services	$0 (deductible waived)

Infertility services and supplies are described below in the "Infertility services" section.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

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..... $5 (deductible waived)

Pediatric Vision care (birth through age 18)

Pediatric vision benefits are administered by EyeMed Vision Care, LLC, a contracted vision services provider panel. Refer to the "Pediatric Vision Care Program" section later in this SB/DF for the benefit information which includes the Eyewear Schedule.

Pediatric dental (birth through age 18) (in California only)

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, except as referred by your Physician Group 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 Plan Contract and 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 services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the plan's EOC. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- 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; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.
- 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.

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 NON-EMERGENCY HEALTH CARE SERVICES

The California Department of Managed Health Care (DMHC) has issued 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.

SPECIAL ENROLLMENT RIGHTS IF YOU LOSE ELIGIBILITY FROM THE ACCESS FOR INFANTS OR MOTHERS PROGRAM (AIM) OR A MEDI-CAL PLAN

If you become ineligible and lose coverage under the Access for Infants or Mothers Program (AIM) or 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 the Access for Infants and Mothers Program (AIM) or 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 *means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency Care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, 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).

Urgently needed care *means any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine 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 reasonably 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 patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. 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 14702

Lexington, KY 40512

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 emergency acupuncture service or for other approved 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 by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the second 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 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.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please call the Health Net 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 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. No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

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.

If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net 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 IV (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 I drugs - Drugs listed as Tier I on the Essential Rx Drug List that are not excluded from coverage (most generic drugs and low cost preferred brand name drugs listed on the Essential Rx Drug List);
- Tier II drugs – Drugs listed as Tier II on the Essential Rx Drug List that are not excluded from coverage (non-preferred generic and preferred Brand Name Drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Essential Rx Drug List); and
- Tier III drugs - Drugs listed on the Essential Rx Drug List as Tier III (non-preferred Brand Name Drugs, drugs listed as Tier III Drugs or drugs not listed in the Essential Rx Drug List)
- Tier IV (Specialty Drugs) - typically provided through a Specialty Pharmacy Vendor
- Preventive drugs, including smoking cessation 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 (per member each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies, and preventive drugs, including smoking cessation drugs,and 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.
- If the pharmacy's retail price is less than the applicable copayment, the member will only pay the pharmacy's retail price.
- 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. 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 IV (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 IV (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 IV (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 IV (Specialty) Drugs are not available through mail order.

- All Tier IV (Specialty Drugs) require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier IV (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. 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 diabetesor 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. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;

- 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;
- Replacement of lost, stolen or damaged medications
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net; 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 nonroutine complications of a noncovered service.

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

Acupuncture care program

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; and
- Emergency acupuncture services.

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 emergency acupuncture services are provided or 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 emergency acupuncture services or 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 EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits. EyeMed Vision Care 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 EyeMed Vision Care. To find a participating eyewear dispenser, call the Health Net Vision Program at **1-866-392-6058** or visit our website at www.healthnet.com**.**

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 –
- Photocromatic / 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, Prior Authorization from Health Net 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, Prior Authorization by Health Net and all applicable exclusions and limitations. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames.

- Hospital and medical charges of any kind, vision services rendered in a hospital and medical or surgical treatment of the eyes, are not covered
- 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 Services" portion of "Exclusions and Limitations" for limitations on covered pediatric dental services.

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 this evidence of coverage document.

SCHEDULE OF COVERED DENTAL SERVICES

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation – established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0210	X-rays Intraoral - complete series (including bitewings)	$0
D0220	X-rays Intraoral - periapical first film	$0
D0230	X-rays Intraoral - periapical each additional film	$0
D0240	X-rays Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each additional film	$0
D0270	X-rays Bitewing - single film	$0
D0272	X-rays Bitewings - two films	$0
D0273	X-rays Bitewings - three films	$0
D0274	X-rays Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
D0415	Collect Microorganisms cult & and sensitivity	$0
D0425	Caries Susceptibility tests	$0
D0431	Adjunct pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of	$0

Code	Service	Member Co-payment
	written report	
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moder-ate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0999	Office visit fee – per visit	$0
Preventive		
D1120	Prophylaxis - child	$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
D1208	Topical application of fluoride - child	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1352	Prevent resin rest in mod to high risk patients	$0
D1510	Space maintainer - fixed - unilateral	$0
D1515	Space maintainer - fixed - bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Re-cementation of space maintainer	$0
D1555	Removal of fixed space maintainer	$0
Restorative		
D2140	Amalgam - one surface, primary or permanent	$25
D2150	Amalgam - two surfaces, primary or permanent	$25
D2160	Amalgam - three surfaces, primary or permanent	$25
D2161	Amalgam - four or more surfaces, primary or permanent	$25
D2330	Resin-based composite - one surface, anterior	$25

Code	Service	Member Co-payment
D2331	Resin-based composite - two surfaces, anterior	$25
D2332	Resin-based composite - three surfaces, anterior	$25
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$25
D2390	Resin-based composite crown, anterior	$25
D2391	Resin-based composite - one surface, posterior (permanent tooth)	$25
D2392	Resin-based composite - two surfaces, posterior (permanent tooth)	$25
D2393	Resin-based composite - three surfaces, posterior (permanent tooth)	$25
D2394	Resin-based composite - four or more surfaces, posterior (permanent tooth)	$25
D2510	Inlay - metallic - one surface	$235
D2520	Inlay - metallic - two surfaces	$245
D2530	Inlay - metallic - three or more surfaces	$260
D2542	Onlay - metallic - two surfaces	$275
D2543	Onlay - metallic - three surfaces	$285
D2544	Onlay - metallic - four or more surfaces	$300
D2610	Inlay – porcelain/ceramic – 1 surface	$275
D2620	Inlay – porcelain/ceramic – 2 surfaces	$285
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	$300
D2642	Onlay – porcelain/ceramic – 2 surfaces	$285
D2643	Onlay – porcelain/ceramic – 3 surfaces	$300
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	$300
D2650	Inlay – resin based composite – 1 surface	$215
D2651	Inlay – resin based composite – 2 surfaces	$235
D2652	Inlay – resin based composite – 3 or more surfaces	$245
D2662	Onlay – resin based composite – 2 surfaces	$225
D2663	Onlay – resin based composite – 3 surfaces	$255
D2664	Onlay – resin based composite – 4 or more surfaces	$275
Crowns - Single Restorations Only		
D2710	Crown – Resin-based composite (indirect)	$140
D2712	Crown – ¾ resin-based composite (indirect)	$140
D2720	Crown – Resin with high noble metal	$300
D2721	Crown – Resin with predominantly base metal	$300

Code	Service	Member Co-payment
D2722	Crown – Resin with noble metal	$300
D2740	Crown - porcelain/ceramic substrate	$300
D2750	Crown - porcelain fused to high noble metal	$300
D2751	Crown - porcelain fused to predominantly base metal	$300
D2752	Crown - porcelain fused to noble metal	$300
D2780	Crown - 3/4 cast high noble metal	$300
D2781	Crown - 3/4 cast predominantly base metal	$300
D2782	Crown - 3/4 cast noble metal	$300
D2783	Crown - 3/4 porcelain/ceramic	$300
D2790	Crown - full cast high noble metal	$300
D2791	Crown - full cast predominantly base metal	$300
D2792	Crown - full cast noble metal	$300
D2794	Crown - titanium	$300
D2910	Recement inlay, onlay, or partial coverage restoration	$35
D2915	Recement cast or prefabricated post and core	$35
D2920	Recement crown	$35
D2921	Re-attachment of tooth fragment, incisal edge or cusp	$25
D2930	Prefabricated stainless steel crown - primary tooth	$85
D2931	Prefabricated stainless steel crown - permanent tooth	$100
D2932	Prefabricated Resin Crown	$100
D2933	Prefabricated Stainless steel crown resin window	$120
D2934	Prefabricated Esthetic coated Stainless steel	$115
D2940	Sedative filling	$25
D2941	Interim therapeutic restoration – primary dentition	$25
D2950	Core buildup, including any pins	$80
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Cast post and core in addition to crown, indirectly fabricated	$110
D2953	Each additional indirectly fabricated cast post - same tooth	$65
D2954	Prefabricated post and core in addition to crown	$94
D2955	Post removal	$30
D2957	Each additional prefabricated post – same tooth	$64

Code	Service	Member Co-payment
D2960	Labial veneer (resin based) – chairside	$270
D2962	Labial veneer (porcelain laminate)	$300
D2970	Temporary crown	$0
D2971	Additional procedures to construct new crown under existing partial dental framework	$65
D2980	Crown repair, by report	$70
D2981	Inlay repair necessitated by restorative material failure	$70
D2982	Onlay repair necessitated by restorative material failure	$70
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	$15
D3120	Pulp cap - indirect (excluding final restoration)	$15
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$75
D3221	Pupal debri primary and permanent teeth	$55
D3222	Partial Pulpotomy for apexogenesis	$55
D3230	Pulpal therapy - anterior, primary tooth	$60
D3240	Pulpal therapy - posterior, primary tooth	$70
D3310	Anterior (excluding final restoration)	$195
D3320	Bicuspid (excluding final restoration)	$275
D3330	Molar (excluding final restoration)	$300
D3331	Treatment of root canal obstruction; non-surgical access	$105
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$105
D3333	Internal root repair of perforation defects	$105
D3346	Retreatment of previous root canal therapy - anterior	$275
D3347	Retreatment of previous root canal therapy - bicuspid	$300
D3348	Retreatment of previous root canal therapy - molar	$300
D3351	Apexification/recalcification - initial visit	$110
D3352	Apexification/recalcification - interim	$55
D3353	Apexification/recalcification - final visit	$175
D3355	Pulpal regeneration - initial visit	$110
D3356	Pulpal regeneration -interim medicament replacement	$55

Code	Service	Member Co-payment
D3357	Pulpal regeneration - completion of treatment	$175
D3410	Apicoectomy/periradicular surgery - anterior	$265
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$295
D3425	Apicoectomy/periradicular surgery - molar (first root)	$300
D3426	Apicoectomy/periradicular surgery (each additional root)	$90
D3427	Periradicular surgery without apicoectomy	$90
D3430	Retrograde filling - per root	$65
D3450	Root amputation - per root	$135
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3920	Hemisection (including any root removal0, not including root canal therapy	$115
D3950	Canal preparation and fitting of preformed dowel or post	$30
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$75
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$225
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$155
D4245	Apically positioned flap	$240
D4249	Clinical crown lengthening - hard tissue	$175
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$300
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$275
D4263	Bone replacement graft – first site in quadrant	$225
D4264	Bone replacement graft – each additional site in quadrant	$135
D4270	Pedicle soft tissue graft procedure	$285
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$95
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$285

Code	Service	Member Co-payment
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	$65
D4342	Periodontal scaling and root planing - one to three teeth - per quadrant	$35
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$65
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$35
D4910	Periodontal maintenance	$45
D4920	Unscheduled dressing changed	$0
Prosthodontics		
D5110	Complete denture - maxillary	$300
D5120	Complete denture - mandibular	$300
D5130	Immediate denture - maxillary	$300
D5140	Immediate denture - mandibular	$300
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$300
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$300
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$300
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$300
D5281	Remv Uni Part Denture – 1 PC cast metal	$290
D5410	Adjust complete denture - maxillary	$25
D5411	Adjust complete denture - mandibular	$25
D5421	Adjust partial denture - maxillary	$25
D5422	Adjust partial denture - mandibular	$25
D5510	Repair broken complete denture base	$55
D5520	Replace missing or broken teeth - complete denture (each tooth)	$45
D5610	Repair resin denture base	$55
D5620	Repair cast framework	$55
D5630	Repair or replace broken clasp	$60

Code	Service	Member Co-payment
D5640	Replace broken teeth - per tooth	$48
D5650	Add tooth to existing partial denture	$55
D5660	Add clasp to existing partial denture	$65
D5670	Replace all teeth & acrylic framework maxillary	$175
D5671	Replace all teeth & acrylic framework mandibular	$175
D5710	Rebase complete maxillary denture	$180
D5711	Rebase complete mandibular denture	$180
D5720	Rebase maxillary partial denture	$170
D5721	Rebase mandibular partial denture	$170
D5730	Reline complete maxillary denture (chairside)	$95
D5731	Reline complete mandibular denture (chairside)	$95
D5740	Reline maxillary partial denture (chairside)	$95
D5741	Reline mandibular partial denture (chairside)	$95
D5750	Reline complete maxillary denture (laboratory)	$135
D5751	Reline complete mandibular denture (laboratory)	$135
D5760	Reline maxillary partial denture (laboratory)	$135
D5761	Reline mandibular partial denture (laboratory)	$135
D5820	Interim partial denture (maxillary)	$165
D5821	Interim partial denture (mandibular)	$165
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
D5863	Overdenture - complete maxillary	$300
D5864	Overdenture - complete mandibular	$300
D5865	Overdenture - partial maxillary	$300
D5866	Overdenture - partial mandibular	$300
D5999	Denture duplication	$225
Prosthodontics (Fixed)		
D6205	Pontic – indirect resin-based composite	$175
D6210	Pontic - cast high noble metal	$300
D6211	Pontic - cast predominantly base metal	$300
D6212	Pontic - cast noble metal	$300

Code	Service	Member Co-payment
D6214	Pontic - titanium	$300
D6240	Pontic - porcelain fused to high noble metal	$300
D6241	Pontic - porcelain fused to predominantly base metal	$300
D6242	Pontic - porcelain fused to noble metal	$300
D6245	Pontic - porcelain/ceramic	$300
D6250	Crown - porcelain fused to high noble metal	$300
D6251	Crown - porcelain fused to predominantly base metal	$300
D6252	Crown - porcelain fused to noble metal	$300
D6600	Inlay – porcelain/ceramic, 2 surfaces	$285
D6601	Inlay – porcelain/ceramic, 3 or more surfaces	$300
D6602	Inlay – cast high noble metal, 2 surfaces	$245
D6603	Inlay – cast high noble metal, 3 or more surfaces	$260
D6604	Inlay – cast predominantly base metal, 2 surfaces	$235
D6605	Inlay – cast predominantly base metal, 3 ore more surfaces	$250
D6606	Inlay – cast noble metal, 2 surfaces	$235
D6607	Inlay – cast noble metal, 3 or more surfaces	$255
D6608	Onlay – porcelain/ceramic, 2 surfaces	$250
D6609	Onlay – porcelain/ceramic, 3 or more surfaces	$255
D6610	Onlay – cast high noble metal 2 surfaces	$300
D6611	Onlay – cast high noble metal 3 or more surfaces	$300
D6612	Onlay – cast predominantly base metal 2 surfaces	$300
D6613	Onlay – cast predominantly base metal 3 or more surfaces	$300
D6614	Onlay – cast noble metal 2 surfaces	$300
D6615	Onlay – cast noble metal 3 or more surfaces	$300
D6624	Inlay titanium	$245
D6634	Onlay titanium	$255
D6710	Crown – indirect resin-based composite	$175
D6720	Crown – resin with high noble metal	$300
D6721	Crown – resin predominantly base metal – denture	$300
D6722	Crown –resin with noble metal	$300
D6740	Crown – porcelain/ceramic	$300

Code	Service	Member Co-payment
D6750	Crown – porcelain fused to high noble metal	$300
D6751	Crown –porcelain fused to predominantly base metal	$300
D6752	Crown – porcelain fused to noble metal	$300
D6780	Crown - 3/4 cast high noble metal	$300
D6781	Crown - 3/4 cast predominantly base metal	$300
D6782	Crown - 3/4 cast noble metal	$300
D6783	Crown ¾ porcelain/ceramic-denture	$300
D6790	Crown - full cast high noble metal	$300
D6791	Crown - full cast predominantly base metal	$300
D6792	Crown - full cast noble metal	$300
D6794	Crown - titanium	$300
D6930	Recement fixed partial denture	$48
D6940	Stress breaker	$120
D6980	Fixed partial denture repair, by report	$60
Oral Surgery		
D7111	Extraction, coronal remnants - deciduous tooth	$15
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$45
D7220	Removal of impacted tooth - soft tissue	$50
D7230	Removal of impacted tooth - partially bony	$50
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$95
D7250	Surgical removal of residual tooth roots (cutting procedure)	$90
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$65
D7280	Surgical access exposure of an unerupted tooth	$125
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$135
D7285	Biopsy of oral tissue - hard (bone, tooth)	$85
D7286	Biopsy of oral tissue - soft (all others)	$55
D7288	Brush biopsy – transepithelial sample collection	$0

Code	Service	Member Co-payment
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$50
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$40
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$75
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$65
D7410	Excision of benign lesion up 1/25 cm	$175
D7411	Excision of benign lesion greater than 1.25 cm	$300
D7412	Excision of benign lesion, complicated	$300
D7450	Removal of benign odontogenic cyst up to 1.25 cm	$200
D7451	Removal of benign odontogenic cyst greater than 1.25 cm	$285
D7460	Removal of benign noodontogenic cyst up to 1.25 cm	$200
D7461	Removal of benign noodontogenic cyst greater than 1.25 cm	$285
D7471	Removal of lateral exostosis	$165
D7472	Removal of torus palatines	$300
D7473	Removal of torus mandibularis	$265
D7485	Surgical reduction of osseous tuberosity	$75
D7510	Incision and drainage of abscess - intraoral soft tissue	$20
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$35
D7520	Incision and drainage of abscess – extraoral soft tissue	$275
D7521	Incision and drainage of abscess – extraoral soft tissue - complicated	$300
D7910	Suture of recent small wounds up to 5 cm	$35
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$25
D7963	Frenuloplasty	$55
D7970	Excision of hyperplastic tissue – per arch	$65
D7971	Excision of pericoronal gingiva	$55
D7972	Surgical reduction of fibrous tuberosity	$145
D7999	Unspecified oral surgery procedure, by report	$10

Orthodontics

	Medically Necessary Banded Case	$1000
D8070	Comprehensive orthodontic treatment of the transitional dentition	

Code	Service	Member Co-payment
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8660	Pre-orthodontic treatment visit	
D8999	Unspecified orthodontic procedure, by report	
	Adjunctive General Services	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$5
D9211	Regional block anesthesia	$5
D9212	Trigeminal division block anesthesia	$10
D9215	Local anesthesia	$5
D9220	Deep sedation/general anesthesia - first 30 minutes	$95
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$80
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$10
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$155
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$60
D9248	Non-intravenous conscious sedation	$20
D9310	Consultation - diagnostic service provided by dentist or physician (other than practitioner providing treatment)	$20
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	Office visit - after regularly scheduled hours	$35
D9450	Case presentation, detailed and extensive treatment planning	$0
D9930	Treatment of complications – post surgery	$0
D9940	Occlusal guard by report	$175
D9951	Occlusal adjustment - limited	$55
D9952	Occlusal adjustment – complete	$165
D9972	External bleaching – per arch	$125
D9999	Broken appointment	$10

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:

- Prophylaxis services (cleanings) are limited to two every 12 months.
- Fluoride treatment is covered twice in any 12 month period.
- Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period.
- Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
- Panoramic film x-rays are limited to once every 24 consecutive months
- Dental sealant treatments are limited to permanent first and second molars only.
- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.
- Replacement of a restoration is covered only when it is defective, as evidence by conditions such a recurrent caries or fracture, and replacement is Dentally Necessary.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filing.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person under the age of 19. For children under the age of 19, it is considered optional dental treatment. If performed on a Member under the age of 19, the applicant must pay the difference in cost between the fixed bridge and a space maintainer. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. Fixed bridges are optional when provided in connection with a partial denture on the same arch. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.
- The following services, if in the opinion of the attending dentist or Health Net are not Dentally 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.

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.

Notice of language services

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 us at the number listed on your ID card or please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: call the DMHC Helpline at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Afiliados a PPO: para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados a HMO: llame a la Línea de Ayuda del Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡所列的電話號碼或撥 800-522-0088 與我們聯絡。PPO 會員：如需其他協助，請致電 CA 保險局，電話 1-800-927-4357。HMO 會員：請撥 DMHC 協助專線 1-888-HMO-2219。 **Chinese**

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được cấp người đọc văn bản cho quý vị hoặc nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại trên thẻ hội viên của quý vị hoặc gọi số 800-522-0088. Hội viên chương trình PPO: Để được trợ giúp thêm, vui lòng gọi cho Sở Bảo hiểm CA tại số 1-800-927-4357. Hội viên chương trình HMO: xin gọi Đường dây trợ giúp của Sở DMHC tại 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 귀하는 통역사 서비스를 받으실 수 있습니다. 본인에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 800-522-0088 번으로 연락해 주십시오. PPO 가입자: 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357 번으로 문의하십시오. HMO 가입자: DMHC 헬프라인, 안내번호 1-888-HMO-2219 번으로 문의해 주십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento, at maaaring ipadala sa iyo ang ilan sa mga ito sa iyong wika. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o kaya mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: tawagan ang DMHC Helpline sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ստանալ: Փաստաթղթերը կարող են ձեզ համար ընթերցվել կամ ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ խնդրում ենք զանգահարել 800-522-0088 համարով: PPO անդամներ՝ լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance) 1-800-927-4357 համարով: HMO անդամներ՝ զանգահարեք DMHC-ի Օգնության գծին 1-888-HMO-2219 համարով: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут прочесть вашu документы, а также выслать вам некоторые из них на вашем языке. Для получения помощи звоните нам по номеру телефона, указанному в вашей карточке-удостоверении, или по номеру 800-522-0088. Просим участников плана PPO для получения дополнительной помощи звонить в Министерство страхования (Department of Insurance) штата Калифорния по номеру 1-800-927-4357. Участников организаций медицинского обслуживания (HMO) просим обращаться в телефонную службу помощи Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。通訳がご利用になれ、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカード記載の番号または 800-522-0088 までご連絡ください。PPO加入者: その他のお問い合わせはカリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMO加入者: DMHCヘルプライン、1-888-HMO-2219 までご連絡ください。 **Japanese**

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شده و بعضی از آنها به زبان خودتان برایتان ارسال شوند. برای دریافت کمک، به ما به شماره ای که روی کارت هویتتان قید شده است تلفن کنید و یا با شماره 800-522-0088 تماس بگیرید. اعضاء PPO: برای دریافت کمک بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO : با خط تلفنی کمکی DMHC به شماره 1-888-HMO-2219 تماس بگیرید. **Farsi**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਕਿਸੇ ਵੀ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਹੋਰ ਸਹਾਇਤਾ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការបកប្រែភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងឆ្លើឯកសារខ្លះ ទៅឲ្យអ្នក ជាភាសាខ្មែរបាន។ សំរាប់ជំនួយសូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទ ទៅលេខ 800-522-0088។ សមាជិក PPO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួង ធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនី្ញ តាមលេខ 1-800-927-4357។ សមាជិក HMO: សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم. يمكنك طلب قراءة وثائق وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) أو رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية يمكنهم الاتصال بـ CA Dept. of Insurance على الرقم 1-800-927-4357. أعضاء برنامج HMO: يمكنهم الاتصال بخط المساعدة التابع لـ DMHC بواسطة الرقم 1-888-HMO-2219. **Arabic**

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus. Koj muab tau cov ntawv nyeem rau koj thiab ib co xa tuaj rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID lossis thov hu 800-522-0088. Cov tswv cuab PPO: kom tau kev pab ntxiv hu rau lub CA Dept. of Insurance ntawm 1-800-927-4357. Cov tswv cuab HMO: hu rau lub DMHC Helpline ntawm 1-888-HMO-2219. **Hmong**

Doo bąąh hiliní da hazaad bee haká'adoowołgo. Ata' halne'é ła' áka'adoolwołgíí jóki'. Naaltsoos bínahjį' éé dahózinígíí hach'į' yíídooltah áádóó ła' hach'į' adoolyiił t'áá hó hazaad k'ehjí. Aká'adoowoł biniiyé, nihich'į' hódíílnih béésh bee hane'é binumber bee néé hó'dolzin biniiyé nanitinígíí bikáá' éí doodaií kojį' hodíílnih 800-522-0088. PPO atah jiłíigo: t'áá náás bee shiká'anáá'doowoł ninizingo kojį' hodíílnih CA Dept of Insurancejį' éí 1-800-927-4357. HMO atah jiłíigo: kojį' hodíílnih DMHC béésh bee hane'é bee aká'a'áyeedjį' éí 1-888-HMO-2219. **Navajo**

CONTACT US

For more information, please contact us at:

Health Net
Post Office Box 10348
Van Nuys, California 91409-10348

Customer Contact Center

Large Business Group:
1-800-522-0088 (English)
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)

Telecommunications Device
for the Hearing and Speech Impaired:
1-800-995-0852