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

Small Business Group
Health Net Silver 70 HSP 2000/45 + INF Plan CZS

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, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, Domestic Partner status or religion, and are not subject to any pre-existing condition or exclusion period.

If you have further questions, contact us:

By phone at 1-800-361-3366,

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

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 an*d *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 PURECARE HSP NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM PURECARE NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

Except for Emergency and Urgently Needed Care, benefits for Physician and Hospital services under this **Health Net PureCare HSP Network** ("PureCare Network") plan are only available when you live or work in the PureCare Network service area and use a PureCare Network Participating Physician or Hospital. When you enroll in this PureCare Network plan, you may only use a Participating Physician or Hospital who is in the PureCare Network and you are required to choose a PureCare 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 PureCare HSP Network Plan

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY	BEHAVIORAL HEALTH
AVAILABLE FROM	*Only PureCare Network Hospitals	*Only PureCare 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 PureCare Network Participating Physician or Hospital, except for Emergency and Urgently Needed Care. Please refer to the "Introduction to Health Net" section for more details on referrals and how to obtain Emergency and Urgently Needed Care.					

The PureCare Network service area and a list of its Participating Physician and Hospital providers are shown in the Health Net *PureCare HSP Network Provider Directory,* which is available online at our website www.healthnet.com. You can also call the Health Net Customer Contact Center at 1-800-522-0088 to request provider information. The *PureCare HSP Network Provider Directory* is different from other Health Net Provider Directories.

Note: Not all Physician and Hospitals who contract with Health Net are PureCare Network Participating Providers. Only those Physicians and Hospitals specifically identified as Participating Providers in the PureCare 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 PureCare Network as explained above.

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

Health Net PureCare HSP Network Alternative Access Standards

The PureCare Network includes participating primary care and Specialist Physicians, and Hospitals in the PureCare service area. However, PureCare 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

Alameda County: 94550 – Livermore (PCP and Hospital)

Contra Costa County: 94509 – Antioch (Hospital), **94511** – Bethel Island (Hospital), **94513** – Brentwood (Hospital), **94514** – Byron (Hospital), **94548** – Knightsen (Hospital), **94561** – Oakley (Hospital)

Fresno County: 93624 – Five Points (Hospital), 93630 – Kerman (Hospital), **93641** – Miramonte (Hospital), **93656** – Riverdale (Hospital), 93657 – Sanger (Hospital), **93660** – San Joaquin (Hospital), **93664** – Shaver Lake (PCP), **93667** – Tollhouse (Hospital), **93706** – Fresno (Hospital)

Kern County: 93203 – Arvin (Hospital), **93222** – Frazier Park (Hospital), **93252** – Maricopa (PCP), **93255** – Onyx (PCP), **93263** –Shafter (Hospital), **93280** – Wasco (Hospital), **93287** – Woody (Hospital), **93308** – Bakersfield (Hospital), **93311** – Bakersfield (PCP and Hospital), **93313** – Bakersfield (Hospital), **93501** – Mojave (Hospital), **93504** – California City (Hospital), **93505** – California City (Hospital), **93519** – Cantil (PCP), **93560** – Rosamond (PCP and Hospital)

Kings County: 93239 – Kettleman City (PCP), **93266** – Stratford (Hospital)

Los Angeles County: 90265 – Malibu (Hospital), **91390** – Santa Clarita (Hospital), **93532** – Lake Hughes (Hospital), **93535** – Lancaster (PCP and Hospital), **93536** – Lancaster (PCP and Hospital), **93543** – Littlerock (Hospital), **93544** – Llano (Hospital), **93553** – Pearblossom (Hospital), **93563** – Valyermo (Hospital), **93591** – Palmdale (Hospital)

Madera County: 93610 – Chowchilla (Hospital), **93626** – Friant (Hospital), **93636** – Madera (Hospital), **93645** – O'Neals (Hospital)

Marin County: 94937 – Inverness (Hospital), **94956** – Point Reyes Station (Hospital)

Merced County: 93661 – Santa Rita Park (Hospital), **93665** – South Dos Palos (Hospital), **95333** – Le Grand (Hospital), **95341** – Merced (Hospital)

Placer County: 95603 – Auburn (Hospital), **95604** – Auburn (Hospital), **95648** – Lincoln (Hospital), **95681 –** Sheridan (Hospital)

Riverside County: 92274 – Thermal (Hospital), **92536** – Aguanga (Hospital), **92539** – Anza (Hospital), **92544** – Hemet (Hospital), **92592** – Temecula (Hospital), **92593** – Temecula (Hospital)

Sacramento County: 95615 Courtland (Hospital), **95638** – Herald (Hospital), **95641** – Isleton (Hospital), **95680** – Ryde (Hospital), **95690** – Walnut Grove (Hospital)

San Bernardino County: 92285 – Yucca Valley (Hospital), **92301** – Adelanto (Hospital), **92347** – Hinkley (Hospital), **92365** – Newberry Springs (PCP and Hospital), **92372** – Pinon Hills (Hospital), **92397** – Wrightwood (Hospital)

San Diego County: 91901 – Alpine (Hospital), **91916** – Descanso (Hospital), **91917** – Dulzura (Hospital), **91931** – Imperial Beach (Hospital), **91963** – Potrero (Hospital), **92021** – El Cajon (Hospital), **92040** – Lakeside (Hospital), **92059** – Pala (Hospital), **92060** – Palomar Mountain (Hospital), **92061** – Pauma Valley (Hospital), **92065** – Ramona (Hospital), **92070** – Santa Ysabel (Hospital)

San Joaquin County: 95206 – Stockton (Hospital), **95219** – Stockton (Hospital), **95376** – Tracy (Hospital), **95377** – Tracy (Hospital), **95378** – Tracy (Hospital), **95391** – Tracy (Hospital)

San Mateo County: 94021 Loma Mar (Hospital), **94060** – Pescadero (Hospital)

Santa Clara County: 95037 – Morgan Hill (Hospital), **95141** – San Jose (Hospital)

Santa Cruz County: 95060 – Santa Cruz (Hospital)

Solano County: 94512 Birds Landing (Hospital), **94571** – Rio Vista (Hospital), **94589** – Vallejo (Hospital), **94590** – Vallejo (Hospital), **94591** – Vallejo (Hospital)

Sonoma County: 94923 – Bodega Bay (Hospital), **94952** – Petaluma (Hospital), **95412** – Annapolis (PCP), **95421** – Cazadero (Hospital), **95425** – Cloverdale (Hospital), **95450** – Jenner (Hospital), **95480** – Stewarts Point (PCP and Hospital), **95497** – Gualala (PCP)

Stanislaus County: 95313 – Crows Landing (Hospital), **95329** – La Grange (Hospital), **95360** – Newman (Hospital), **95363** – Patterson (Hospital), **95386** – Waterford (Hospital)

Tulare County: 93207 – California Hot Springs (Hospital), **93208** – Camp Nelson (Hospital), **93237** – Kaweah (Hospital), **93260** – Posey (Hospital), **93265** – Springville (Hospital), **93286** – Woodlake (Hospital), **93292** – Visalia (Hospital), **93603** – Badger (Hospital)

Beyond 30 Miles

Fresno County: 93210 – Coalinga (Hospital: 58 miles), **93234** – Huron (Hospital: 43 miles), **93602** – Auberry (Hospital: 33 miles), **93605** – Big Creek (Hospital: 44 miles), **93608** – Cantua Creek (Hospital: 45 miles), **93621** – Dunlap (Hospital: 32 miles), **93622** – Firebaugh (Hospital: 45 miles), **93627** – Helm (Hospital: 37 miles), **93628** – Hume (Hospital: 38 miles), **93634** – Lakeshore (Hospital: 49 miles), **93640** – Mendota (Hospital: 43 miles), **93642** – Mono Hot Springs (Hospital: 53 miles), **93664** – Shaver Lake (Hospital: 56 miles), **93668** – Tranquility (Hospital: 36 miles)

Kern County: 93206 – Buttonwillow (Hospital: 35 miles), **93224** – Fellows (Hospital: 38 miles), **93225** – Frazier Park (Hospital: 33 miles), **93243** – Lebec (PCP: 38 miles and Hospital: 38 miles), **93249** – Lost Hills (PCP: 35 miles and Hospital: 54 miles), **93251** – McKittrick (Hospital: 41 miles), **93252** – Maricopa (Hospital: 40 miles), **93268** – Taft (Hospital: 33 miles), **93516** – Boron (Hospital: 42 miles), **93519** – Cantil (Hospital: 35 miles), **93523** – Edwards Air Force Base (Hospital: 39 miles), **93524** – Edwards Air Force Base (Hospital: 39 miles), **93596** – Boron (Hospital: 39 miles)

Kings County: 93204 – Avenal (Hospital 45 miles), **93239** – Kettleman City (Hospital: 39 miles)

Los Angeles County: 90704 – Avalon (PCP: 38 miles and Hospital: 38 miles)

Madera County: 93601 – Ahwahnee (Hospital: 38 miles), **93604** – Bass Lake (Hospital: 36 miles), **93614** – Coarsegold (Hospital: 32 miles), **93643** – North Fork (Hospital: 39 miles), **93644** – Oakhurst (Hospital: 42 miles), **93653** – Raymond (Hospital: 35 miles), **93669** – Wishon (Hospital: 35 miles)

Merced County: 93620 – Dos Palos (Hospital: 32 miles), **93635** – Los Banos (Hospital: 39 miles), **95322** – Gustine (Hospital: 33 miles)

Nevada County: 95959 – Nevada City (Hospital: 31 miles)

Riverside County: 92254 – Mecca (Hospital: 32 miles)

San Bernardino County: 92277 – Twentynine Palms (Hospital: 30 miles), **92278** – Twentynine Palms (PCP: 40 miles and Hospital: 44 miles), **92309** – Baker (PCP: 105 miles and Hospital: 106 miles), 92310 – Fort Irwin (PCP: 40 miles and Hospital: 41 miles)

San Diego County: 91905 – Boulevard (Hospital: 46 miles), **91906** – Campo (Hospital: 40 miles), **91934** – Jacumba (Hospital: 55 miles), **91948** – Mt. Laguna (Hospital: 37 miles), **91962** – Pine Valley (Hospital: 40 miles), **91980** – Tecate (Hospital: 37 miles), **92004** – Borrego Springs (Hospital: 47 miles), **92036** – Julian (Hospital: 48 miles), **92066** – Ranchita (Hospital: 38 miles), **92086** – Warner Springs (Hospital: 37 miles)

Santa Barbara County: 93254 – New Cuyama (PCP: 32 miles and Hospital: 37 miles)

Sonoma County: 95412 – Annapolis (Hospital: 34 miles), **95497** – Gualala (Hospital: 39 miles)

Tulare County: 93262 – Sequoia National Park (Hospital: 41 miles), **93271** – Three Rivers (Hospital: 32 miles)

Yolo County: 95606 – Brooks (PCP and Hospital: 33 miles), **95637** – Guinda (PCP 32 miles and Hospital: 33 miles), **95679** – Rumsey (PCP and Hospital: 33 miles), **95937** – Dunnigan (PCP: 34 miles and Hospital: 35 miles)

If you have any questions about the PureCare Network Service Area, how to choose a Primary Care Physician, or how to access care or your benefits, please contact the Health Net Customer Contact Center at 1-800-522-0088.

Health Net PureCare HSP Network Alternative Access Standards

The PureCare HSP Network includes participating ancillary providers, including acupuncture, vision and dental services providers, in the PureCare service area. However, in the rural zip codes within the service area identified below, Health Net may not have a contracted provider for acupuncture, vision and/or dental services. If you require medically necessary services from an acupuncture, vision and/or dental services provider in these areas where Health Net does not have a contracted provider for acupuncture, vision and/or dental services, and there are nonparticipating acupuncture, vision and/or dental providers offices located within access standards, Health Net's applicable ancillary provider networks will make arrangements with a nonparticipating acupuncture, vision and/or dental services provider within the access standards who will provide the services to you at the copayment levels described in the "Schedule of Benefits and Copayments" section.

Acupuncture:

Fresno County: 93210 (Coalinga), 93234 (Huron), 93640 (Mendota), 93642 (Mono Hot Springs) and 93664 (Shaver Lake)

Kern County: 93205 (Bodfish), 93240 (Lake Isabella), 93283 (Weldon), 93505 (California City), 93519 (Cantil), 93523 (Edwards) and 93561 (Tehachapi)

Kings County: All Zip Codes in the Kings County Service Area.

Los Angeles County: 90704 (Avalon)

Madera County: 93644 (Oakhurst)

San Bernardino County: 92277 (Twentynine Palms), 92309 (Baker), 92310 (Fort Irwin), 92327 (Daggett) and 92365 (Newberry Springs)

Tulare County: All Zip Codes in the Tulare County Service Area

Vision:

Fresno County: 93628 (Hume)

Kern County: 93243 (Lebec), 93505 (California City), 93516 (Boron), 93519 (Cantil), 93523 (Edwards), 93524 (Edwards) and 93596 (Boron)

Los Angeles County: 90704 (Avalon) and 93243 (Lebec)

San Bernardino County: 92277 (Twenty-Nine Palms), 92309 (Baker), 92310 (Fort Irwin) and 93516 (Boran)

San Diego County: 91905 (Boulevard) and 92004 (Borrego Springs)

Tulare County: 93262 (Sequoia National Park)

Dental:

Primary Care Dentists and General Dentists:

Contra Costa County: 94513 (Brentwood)

El Dorado County: 95619 (Diamond Springs), 95633 (Garden Valley), 95634 (Georgetown), 95635 (Greenwood), 95636 (Grizzly Flats), 95667 (Placerville), (95684), Somerset), 95709 (Camino) and 95726 (Pollock Pines)

Fresno County: 93210 (Coalinga), 93234 (Huron), 93242 (Laton), 93602 (Auberry), 93603 (Badger), 93605 (Big Creek), 93607 (Burrel), 93608 (Cantua Creek), 93609 (Caruthers), 93619 (Clovis), 93620 (Dos Palos), 93621 (Dunlap), 93622 (Firebaugh), 93624 (Five Points), 93627 (Helm), 93628 (Hume), 93630 (Kerman), 93631 (Kingsburg), 93634 (Lakeshore), 93640

(Mendota), 93641 (Miramonte), 93642 (Mono Hot Springs), 93646 (Orange Cove), 93648 (Parlier), 93649 (Piedra), 93651 (Prather), 93654 (Reedley), 93656 (Riverdale), 93657 (Sanger), 93660 (San Joaquin), 93662 (Selma), 93664 (Shaver Lake), 93667 (Tollhouse), 93668 (Tranquillity), 93675 (Squaw Valley), 93706 (Fresno) and 93725 (Fresno)

Kern County: 93203 (Arvin), 93205 (Bodfish), 93206 (Buttonwillow), 93215 (Delano), 93216 (Delano), 93222 (Pine Mountain Club), 93224 (Fellows), 93225 (Frazier Park), 93226 (Glennville), 93238 (Kernville), 93240 (Lake Isabella), 93243 (Lebec), 93249 (Lost Hills), 93250 (Mc Farland), 93251 (Mc Kittrick), 93252 (Maricopa), 93255 (Onyx), 93263 (Shafter), 93268 (Taft), 93276 (Tupman), 93280 (Wasco), 93283 (Weldon), 93285 (Wofford Heights), 93287 (Woody), 93307 (Bakersfield), 93308 (Bakersfield), 93311 (Bakersfield), 93313 (Bakersfield), 93314 (Bakersfield), 93501 (Mojave), 93502 (Mojave), 93504 (California City), 93505 (California City), 93516 (Boron), 93518 (Caliente), 93519 (Cantil), 93523 (Edwards), 93524 (Edwards), 93531 (Keene), 93536 (Lancaster), 93560 (Rosamond), 93561 (Tehachapi), 93581 (Tehachapi) and 93596 (Boron)

Kings County: 93202 (Armona), 93204 (Avenal), 93212 (Corcoran), 93230 (Hanford), 93631 (Kingsburg), 93232 (Hanford), 93239 (Kettleman City), 93242 (Laton), 93245 (Lemoore), 93266 (Stratford) and 93656 (Riverdale)

Los Angeles County: 90704 (Avalon), 91390 (Santa Clarita), 93243 (Lebec), 93532 (Lake Hughes), 93535 (Lancaster), 93536 (Lancaster), 93543 (Littlerock), 93544 (Llano), 93553 (Pearblossom), 93563 (Valyermo), 93591 (Palmdale)

Madera County: 93601 (Ahwahnee), 93604 (Bass Lake), 93610 (Chowchilla), 93614 (Coarsegold), 93622 (Firebaugh), 93626 (Friant), 93636 (Madera), 93637 (Madera), 93638 (Madera), 93639 (Madera), 93643 (North Fork), 93644 (Oakhurst), 93645 (O Neals), 93653 (Raymond) and 93669 (Wishon)

Marin County: 94901 (San Rafael), 94903 (San Rafael), 94904 (Greenbrae), 94912 (San Rafael), 94913 (San Rafael), 94914 (Kentfield), 94924 (Bolinas), 94929 (Dillon Beach), 94930(Fairfax), 94933 (Forest Knolls), 94937 (Inverness), 94938 (Lagunitas), 94939 (Larkspur), 94940 (Marshall), 94945 (Novato), 94946 (Nicasio), 94947 (Novato), 94948 (Novato), 94949 (Novato), 94950 (Olema), 94952 (Petaluma), 94956 (Point Reyes Station), 94957 (Ross), 94960 (San Anselmo), 94963 (San Geronimo), 94970 (Stinson Beach), 94971 (Tomales), 94973 (Woodacre), 94978 (Fairfax), 94979 (San Anselmo) and 94998 (Novato)

Merced County: 93610 (Chowchilla), 93620 (Dos Palos), 93622 (Firebaugh), 93635 (Los Banos), 93661 (Santa Rita Park), 93665 (South Dos Palos), 95301 (Atwater), 95303 (Ballico), 95312 (Cressey), 95315 (Delhi), 95317 (El Nido), 95322 (Gustine), 95324 (Hilmar), 95333 (Le Grand), 95334 (Livingston), 95340 (Merced), 95341 (Merced), 95343 (Merced), 95344 (Merced), 95348 (Merced), 95360 (Newman), 95365 (Planada), 95369 (Snelling), 95374 (Stevinson), 95380 (Turlock) and 95388 (Winton)

Napa County: 94508 (Angwin), 94515 (Calistoga), 94558 (Napa), 94567 (Pope Valley), 94574 (Saint Helena) and 94576 (Deer Park)

Nevada County: All Zip Codes in the Nevada County Service Area.

Placer County: 95603 (Auburn), 95631 (Foresthill), 95701 (Alta), 95703 (Applegate), 95713 (Colfax), 95714 (Dutch Flat), 95722 (Meadow Vista), 95736 (Weimar)

Riverside County: 92220 (Banning), 92223 (Beaumont), 92230 (Cabazon), 92234 (Cathedral City), 92235 (Cathedral City), 92240 (Desert Hot Springs), 92241 (Desert Hot Springs), 92254 (Mecca), 92258 (North Palm Springs), 92262 (Palm Springs), 92263 (Palm Springs), 92264 (Palm Springs), 92274 (Thermal), 92282 (Whitewater), 92539 (Anza) and 92561 (Mountain Center)

Sacramento County: 95632 (Galt), 95638 (Herald), 95641 (Isleton) and 95690 (Walnut Grove)

San Bernardino County: 92252 (Joshua Tree), 92256 (Morongo Valley), 92268 (Pioneertown), 92277 (Twentynine Palms), 92278 (Twentynine Palms), 92284 (Yucca Valley), 92285 (Lander), 92286 (Yucca Valley), 92301 (Adelanto), 92305 (Angelus Oaks), 92309 (Baker), 92310 (Fort Irwin), 92311 (Barstow), 92312 (Barstow), 92314 (Big Bear City), 92315 (Big Bear Lake), 92327 (Daggett), 92333 (Fawnskin), 92347 (Hinkley), 92356 (Lucerne Valley), 92365 (Newberry Springs), 92386 (Sugarloaf), 92398 (Yermo), 93516 (Boron)

San Diego County: 91901 (Alpine), 91905 (Boulevard), 91906 (Campo), 91916 (Descanso), 91917 (Dulzura), 91931 (Guatay), 91934 (Jacumba), 91948 (Mount Laguna), 91962 (Pine Valley), 91963 (Potrero), 91980 (Tecate), 92004 (Borrego Springs), 92036 (Julian), 92061 (Pauma Valley), 92065 (Ramona), 92066 (Ranchita), 92070 (Santa Ysabel) and 92086 (Warner Springs)

San Joaquin County: 95215 (Stockton), 95220 (Acampo), 95227 (Clements), 95230 (Farmington), 95236 (Linden), 95237 (Lockeford), 95240 (Lodi), 95632 (Galt), and 95638 (Herald)

San Mateo County: 94010 (Burlingame), 94060 (Pescadero) and 94062 (Redwood City), 94401 (San Mateo), and 94402 (San Mateo)

Santa Barbara County: 93013 (Carpinteria), 93014 (Carpinteria), 93067 (Summerland), 93101 (Santa Barbara), 93102 (Santa Barbara), 93103 (Santa Barbara), 93105 (Santa Barbara), 93106 (Santa Barbara), 93107 (Santa Barbara), 93108 (Santa Barbara), 93109 (Santa Barbara), 93110 (Santa Barbara), 93111 (Santa Barbara), 93116 Goleta), 93117 (Goleta), 93118 (Goleta), 93120 (Santa Barbara), 93121 (Santa Barbara), 93130 (Santa Barbara), 93140 (Santa Barbara), 93150 (Santa Barbara), 93160 (Santa Barbara), 93190 (Santa Barbara), 93199 Goleta), 93252 (Maricopa), 93254 New Cuyama), 93427 (Buellton), 93429 (Casmalia), 93434 (Guadalupe), 93436 (Lompoc), 93437 (Lompoc), 93438 (Lompoc), 93440 (Los Alamos), 93441 (Los Olivos), 93454 (Santa Maria), 93455 (Santa Maria), 93456 (Santa Maria), 93457 (Santa Maria), 93458 (Santa Maria), 93460 (Santa Ynez), 93463 (Solvang) and 93464 (Solvang)

Santa Clara County: 95020 (Gilroy)

Santa Cruz County: 94060 (Pescadero), 95001 (Aptos), 95003 (Aptos), 95005 (Ben Lomond), 95010 (Capitola), 95017 (Davenport), 95018 (Felton), 95019 (Freedom), 95041 (Mount Hermon), 95060 (Santa Cruz), 95061 (Santa Cruz), 95062 (Santa Cruz), 95063 (Santa Cruz), 95064 (Santa Cruz), 95065 (Santa Cruz), 95066 (Scotts Valley), 95067 (Scotts Valley), 95073 (Soquel), 95076 (Watsonville) and 95077 (Watsonville)

Solano County: 94571 (Rio Vista), 95620 (Dixon) and 95690 (Walnut Grove)

Sonoma County: 94923 (Bodega Bay), 94952 (Petaluma), 94953 (Petaluma), 94954 (Petaluma), 94955 (Petaluma), 94975 (Petaluma), 94999 (Petaluma), 95412 (Annapolis), 95421 (Cazadero), 95425 (Cloverdale), 95441 (Geyserville), 95446 (Guerneville), 95448 (Healdsburg), 95450 (Jenner), 95480 (Stewarts Point) and 95497 (The Sea Ranch)

Stanislaus County: 95230 (Farmington), 95307 (Ceres), 95313 (Crows Landing), 95316 (Denair), 95322 (Gustine), 95323 (Hickman), 95324 (Hilmar), 95328 (Keyes), 95329 (La Grange), 95360 (Newman), 95361 (Oakdale), 95363 (Patterson), 95380 (Turlock), 95381 (Turlock), 95382 (Turlock) and 95386 (Waterford)

Tulare County: 93201 (Alpaugh), 93207 (California Hot Springs), 93208 (Camp Nelson), 93212 (Corcoran), 93215 (Delano), 93218 (Ducor), 93219 (Earlimart), 93221 (Exeter), 93223 (Farmersville), 93227 (Goshen), 93235 (Ivanhoe), 93237 (Kaweah), 93244 (Lemon Cove), 93247 (Lindsay), 93256 (Pixley), 93257 (Porterville), 93258 (Porterville), 93260 (Posey), 93261(Richgrove), 93262 (Sequoia National Park), 93265 (Springville), 93267 (Strathmore), 93270 (Terra Bella), 93271 (Three Rivers), 93272 (Tipton), 93274 (Tulare), 93275 (Tulare), 93277 (Visalia), 93278 (Visalia), 93279 (Visalia), 93282 (Waukena), 93286 (Woodlake), 93290 (Visalia), 93291 (Visalia), 93292 (Visalia), 93603 (Badger), 93615 (Cutler), 93618 (Dinuba), 93631 (Kingsburg), 93646 (Orange Cove), 93647 (Orosi), 93654 (Reedley), 93666 (Sultana), 93673 (Traver) and 93670 (Yettem)

Ventura County: 93001 (Ventura), 93022 (Oak View), 93023 (Ojai), 93024 (Ojai), and 93252 (Maricopa)

Yolo County: 95606 (Brooks), 95607 (Capay), 95637 (Guinda), 95679 (Rumsey) and 95937 (Dunnigan)

Endodontist:

Fresno County: 93210 (Coalinga), 93234 (Huron), 93605 (Big Creek), 93608 (Cantua Creek), 93620 (Dos Palos), 93622 (Firebaugh), 93628 (Hume), 93634 (Lakeshore), 93640 (Mendota), 93642 (Mono Hot Springs) and 93664 (Shaver Lake)

Kern County: 93249 (Lost Hills), 93516 (Boron), 93519 (Cantil), and 93596 (Boron)

Kings County: 93204 (Avenal), 93212 (Corcoran), 93239 (Kettleman City), and 93266 (Stratford)

Los Angeles County: 90704 (Avalon)

Madera County: 93610 (Chowchilla) and 93644 (Oakhurst)

Merced County: 93610 (Chowchilla), 93620 (Dos Palos), 93622 (Firebaugh), 93635 (Los Banos), 93661 (Santa Rita Park), 93665 (South Dos Palos), 95301 (Atwater), 95317 (El Nido), 95333 (Le Grand), 95340 (Merced), 95341 (Merced), 95343 (Merced), 95344 (Merced), 95348 (Merced), 95365 (Planada), and 95388 (Winton)

Nevada County: 95959 (Nevada City)

San Bernardino County: 92277 (Twentynine Palms), 92278 (Twentynine Palms), 92309 (Baker), 92310 (Fort Irwin), 92327 (Daggett), and 92365 (Newberry Springs)

San Diego County: 91934 (Jacumba), 92004 (Borrego Springs), and 92036 (Julian)

Santa Barbara County: 93429 (Casmalia), 93434 (Guadalupe), 93436 (Lompoc), 93437 (Lompoc), 93438 (Lompoc), 93440 (Los Alamos), 93454 (Santa Maria), 93455 (Santa Maria), 93456 (Santa Maria), 93457 (Santa Maria), and 93458 (Santa Maria)

Sonoma County: 95412 (Annapolis), 95425 (Cloverdale), 95480 (Stewarts Point) and 95497 (The Sea Ranch)

Tulare County: 93207 (California Hot Springs), 93208 (Camp Nelson), 93212 (Corcoran), 93219 (Earlimart), 93221 (Exeter), 93223 (Farmersville), 93227 (Goshen), 93235 (Ivanhoe), 93237 (Kaweah), 93244 (Lemon Cove), 93247 (Lindsay), 93256 (Pixley), 93257 (Porterville), 93258 (Porterville), 93262 (Sequoia National Park), 93265 (Springville), 93267 (Strathmore), 93271 (Three Rivers), 93272 (Tipton), 93274 (Tulare), 93275 (Tulare), 93277 (Visalia), 93278 (Visalia), 93279 (Visalia), 93282 (Waukena), 93286 (Woodlake), 93290 (Visalia), 93291 (Visalia), 93292 (Visalia), and 93603 (Badger)

Oral Surgeon:

Fresno County: 93210 (Coalinga), 93234 (Huron), 93605 (Big Creek), 93608 (Cantua Creek), 93620 (Dos Palos), 93622 (Firebaugh), 93628 (Hume), 93634 (Lakeshore), 93640 (Mendota), 93642 (Mono Hot Springs), and 93664 (Shaver Lake)

Kern County: 93249 (Lost Hills)

Kings County: 93204 (Avenal), 93212 (Corcoran), 93230 (Hanford), 93239 (Kettleman City), 93245 (Lemoore), and 93266 (Stratford)

Los Angeles County: 90704 (Avalon)

Madera County: 93601 (Ahwahnee), 93637 (Madera), and 93644 (Oakhurst)

Merced County: 93620 (Dos Palos), 95301 (Atwater), 95317 (El Nido), 95333 (Le Grand), 95340 (Merced), 95341 (Merced), 95343 (Merced), 95344 (Merced), 95348 (Merced), 95365 (Planada), and 95388 (Winton)

San Bernardino County: 92277 (Twentynine Palms), 92278 (Twentynine Palms), 92309 (Baker), 92310 (Fort Irwin), 92327 (Daggett), and 92365 (Newberry Springs)

San Diego County: 91934 (Jacumba), 92004 (Borrego Springs), and 92036 (Julian)

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Sonoma County: 95412 (Annapolis), 95425 (Cloverdale), 95480 (Stewarts Point) and 95497 (The Sea Ranch)

Tulare County: 93207 (California Hot Springs), 93208 (Camp Nelson), 93212 (Corcoran), 93219 (Earlimart), 93221 (Exeter), 93223 (Farmersville), 93227 (Goshen), 93235 (Ivanhoe), 93237 (Kaweah), 93244 (Lemon Cove), 93247 (Lindsay), 93256 (Pixley), 93257 (Porterville), 93258 (Porterville), 93260 (Posey), 93262 (Sequoia National Park), 93265 (Springville), 93267

(Strathmore), 93271 (Three Rivers), 93272 (Tipton), 93274 (Tulare), 93275 (Tulare), 93277 (Visalia), 93278 (Visalia), 93279 (Visalia), 93282 (Waukena), 93286 (Woodlake), 93290 (Visalia), 93291 (Visalia), 93292 (Visalia), and 93603 (Badger)

Orthodontist:

Fresno County: 93210 (Coalinga), 93605 (Big Creek), 93622 (Firebaugh), 93628 (Hume), 93634 (Lakeshore), 93640 (Mendota), 93642 (Mono Hot Springs), and 93664 (Shaver Lake)

Kern County: 93255 (Onyx), 93516 (Boron), 93519 (Cantil), 93523 (Edwards), and 93596 (Boron)

Los Angeles County: 90704 (Avalon)

Madera County: 93644 (Oakhurst)

Merced County: 93622 (Firebaugh)

San Bernardino County: 92277 (Twentynine Palms), 92278 (Twentynine Palms), 92309 (Baker), 92310 (Fort Irwin), 92327 (Daggett), 92365 (Newberry Springs), and 93516 (Boron)

San Diego County: 91934 (Jacumba), and 92004 (Borrego Springs)

Sonoma County: 95412 (Annapolis), 95425 (Cloverdale), 95480 (Stewarts Point) and 95497 (The Sea Ranch)

Tulare County: 93262 (Sequoia National Park)

Periodontist:

Fresno County: 93210 (Coalinga), 93234 (Huron), 93605 (Big Creek), 93608 (Cantua Creek), 93620 (Dos Palos), 93622 (Firebaugh), 93628 (Hume), 93634 (Lakeshore), 93640 (Mendota), 93642 (Mono Hot Springs), and 93664 (Shaver Lake)

Kern County: 93249 (Lost Hills), 93255 (Onyx), 93516 (Boron), 93519 (Cantil), and 93596 (Boron)

Kings County: 93204 (Avenal), 93212 (Corcoran), 93239 (Kettleman City), and 93266 (Stratford)

Los Angeles County: 90704 (Avalon)

Madera County: 93610 (Chowchilla), and 93644 (Oakhurst)

Merced County: 93620 (Dos Palos), 93622 (Firebaugh), 93635 (Los Banos), 93661 (Santa Rita Park), 93665 (South Dos Palos), 95301 (Atwater), 95317 (El Nido), 95322 (Gustine), 95333 (Le Grand), 95340 (Merced), 95341 (Merced), 95343 (Merced), 95344 (Merced), 95348 (Merced), 95365 (Planada), and 95388 (Winton)

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How the plan works

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

With the Health Net HSP, you may go directly to any PureCare HSP Participating Provider. Simply find the provider you wish to see in the Health Net PureCare HSP Participating Provider Directory and schedule an appointment. Participating Providers accept a special rate, called the Contracted Rate, as payment in full. Your share of costs is based on that Contracted Rate. All benefits of an HSP plan (except Emergency and Urgently Needed Care) must be provided by a Participating Provider in order to be covered.

We believe maintaining an ongoing relationship with a Physician who knows you well and whom you trust is an important part of a good health care program. That's why with PureCare HSP, you are required to select a PCP for yourself and each member of your family. When selecting a PCP, choose a participating physician close enough to your residence to allow reasonable access to medical care. Information on how to select a PCP and a listing of the Participating Physicians in the Health Net PureCare HSP Service Area, are available on the Health Net website at www.healthnet.com. You can also call 1-800-909-3447 to request provider information, or contact your Health Net authorized broker. PCPs include general and family practitioners, internists, pediatricians and obstetricians/gynecologists.

Some of the covered expenses under the PureCare HSP plan are subject to a requirement of Certification in order for a noncertification penalty to not apply. See the "Certification Requirements" below.

CALENDAR YEAR DEDUCTIBLE

A Calendar Year Deductible is required for certain services and is applied to the Out-of-Pocket Maximum. See the "Schedule of Benefits and Coverage" for specific information. You must pay an amount of covered expenses for noted services equal to the Calendar Year Deductible before the benefits are paid by your plan. After the Deductible is satisfied, you remain financially responsible for paying any other applicable copayments until you satisfy the Individual or Family Out-of-Pocket Maximum. If you are a Member in a Family of two or more Members, you reach the Deductible either when you meet the amount for any one Member, or when your entire Family reaches the Family amount. Family deductibles are equal to two times the individual deductible.

OUT-OF-POCKET MAXIMUM

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

CERTIFICATION REQUIREMENTS

Certain covered services require Health Net's review and approval, called certification, before they are obtained. If these services are not certified before they are received, you will be responsible for paying a $250 noncertification penalty. These penalties do not apply to your out-of-pocket maximum. **We may**

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

Services that require certification include:

1. Inpatient admissions[1]
   Any type of facility, including but not limited to:
   - Acute rehabilitation center
   - Substance abuse facility
   - Hospice
   - Hospital
   - Behavioral health facility
   - Skilled Nursing Facility
2. Abdominal paracentesis (when performed at a Hospital)
3. Ambulance: non-emergency air or ground Ambulance services
4. Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorder.
   - Requires notification, certification of diagnosis and treatment plan for the first 6 months; after 6 months prior certification is required for determination of ongoing medical necessity
5. Back surgery
6. Bariatric procedures
7. Blepharoplasty (includes brow ptosis)
8. Breast reductions and augmentations
9. Carpal tunnel (when performed at a Hospital)
10. Cataract surgery (when performed at a Hospital)
11. Chondrocyte implants
12. Cleft palate reconstruction, including dental and orthodontic services
13. Clinical trials
14. Cochlear implants
15. Custom orthotics
16. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
17. Dermatology – inpatient procedures
    - Skin injections and implants
    - Dermabrasion/chemical peel
    - Laser treatment
    - Chemical exfoliation and electrolysis
18. Durable Medical Equipment:
    - Bone growth stimulator
    - Continuous positive airway pressure (CPAP)
    - Custom-made items
    - Hospital beds
    - Power wheelchairs
    - Scooters
19. Enhanced external counterpulsation (EECP)
20. Elective caesarean section
21. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
22. Experimental/Investigational services and new technologies.

23. Genetic testing
24. Hernia repair (when performed at a Hospital)
25. Liposuction
26. Liver biopsy (when performed at a Hospital)
27. Mastectomy for gynecomastia
28. Neuro or spinal cord stimulator
29. Occupational and speech therapy (includes home setting).
30. Orthognathic procedures (includes TMJ treatment)
31. Otoplasty
32. Outpatient Diagnostic procedures:
    - Cardiac catheterization
    - CT (Computerized Tomography)
    - Echocardiography
    - MRA (Magnetic Resonance Imaging)
    - MRI (Magnetic Resonance Imaging)
    - Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
    - PET (Positron Emission Tomography)
    - Sleep studies
33. Outpatient pharmaceuticals
    - Self-injectables
    - Certain Physician-administered drugs, whether administered in a Physician office, free-standing infusion center, ambulatory surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net website, www.healthnet.com, for a list of Physician-administered drugs that require Certification.
34. Outpatient physical therapy and acupuncture (exceeding 12 visits, includes home setting).
35. Prosthesis items exceeding $2,500 in billed charges
36. Rhinoplasty
37. Septoplasty
38. Tonsillectomy and adenectomy (when performed at a Hospital)
39. Total joint replacements (hip, knee, shoulder and ankle)
40. Radiation therapy
41. Transplant related services
42. Gender Reassignment services
43. Treatment of varicose veins
44. Upper and lower gastrointestinal (GI) endoscopy (when performed at a Hospital)
45. Urologic procedures (when performed at a Hospital)
46. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
47. Vermilionectomy with mucosal advancement
48. Vestibuloplasty
49. X-Stop

[1]*Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery or for behavioral health treatment for pervasive developmental disorder or autism.*

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 certification requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

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 PARTICIPATING 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 ..... $2,000 Member/$4,000 Family

For certain medical services and supplies under this plan, a calendar-year deductible applies (except as noted below), which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed the deductible.

Lifetime maximums ..... None

Out-of-Pocket maximum

One member $6,800

Family (two members or more) $13,600

Once your payments for covered services and supplies equals the amount shown above in any one calendar year, including acupuncture 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, such as chiropractic covered services and supplies provided by ASH Plans and infertility services.

Noncertification Penalties

Medically Necessary services for which Certification was required but not obtained $250

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	$45 (deductible waived)
Specialist consultations	$75 (deductible waived)
Prenatal care and preconception visits*	$0 (deductible waived)
Postnatal office visits*	$45 (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	$40 (deductible waived)
Diagnostic imaging (including x-ray) services	$70 (deductible waived)
CT, SPECT, MRI, MUGA and PET	$20% (deductible waived)
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$45 (deductible waived)
Habilitative therapy	$45 (deductible waived)
Organ and stem cell transplants (non-experimental and non-investigational)§	20%
Chemotherapy	20% (deductible waived)
Radiation therapy	20% (deductible waived)
Primary care physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	$45 (deductible waived)
Specialist visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	$75 (deductible waived)
Hearing examination for diagnosis or treatment	$45 (deductible waived)
Vision examination for diagnosis or treatment (for members age 19 and over) by an Optometrist***	$45 (deductible waived)
Vision examination for diagnosis or treatment (for members age 19 and over) by an Ophthalmologist***	$75 (deductible waived)

▲*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 participating provider will determine the most appropriate services, the length of hospital stay will be determined solely by your participating provider.*

§*Deductible waived when services provided in an outpatient surgery setting.*

**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 Deductible or 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	$75 (deductible waived)
Allergy injection services	$45 (deductible waived)
Allergy serum	20% (deductible waived)
Immunizations - To meet foreign travel or occupational requirements	Not covered
Injections (excluding infertility)	
Injectable drugs administered by a physician (per dose)	20% (deductible waived)
Self injectable drugs■	20% up to a maximum of $250 per script after the prescription drug deductible

■*Self-injectable drugs (other than insulin) are considered Tier IV Drugs (Specialty Drugs), and are covered under the Prescription Drug benefit 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% (deductible waived)
Outpatient surgery (surgery performed in a hospital)..... 20% (deductible waived)
Outpatient surgery (performed in an outpatient surgery center)..... 20% (deductible waived)

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 20%
Physician visit to hospital or skilled nursing facility..... 20%

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) ..... $350 (deductible waived)
Emergency room Physician..... $0 (deductible waived)
Urgent care center (professional and facility charges) ..... $45 (deductible waived)

Copayments for emergency room visits will not apply if the member is admitted as an inpatient directly from the emergency room.

Ambulance services

Ground ambulance..... $250
Air ambulance $250

Prescription drug coverage

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

Deductible

Prescription drug deductible (per calendar year)..... $250 Member/$500 Family

The prescription drug deductible must be paid for prescription drug covered services before Health Net begins to pay.

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) ..... $15 prescription drug deductible waived

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) ..... $55 after the prescription drug deductible

Tier III drugs (non-preferred Brand Name Drugs, drugs listed as Tier III Drugs or drugs not listed in the Essential Rx Drug List)	$85 after the prescription Drug deductible
Tier IV Drugs (Specialty Drugs) (typically provided through a Specialty Pharmacy Vendor)	20% up to a maximum of $250 per script after the Prescription drug deductible
Preventive drugs and women's contraceptives	$0 prescription drug deductible waived
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)	$30 prescription drug deductible waived
Tier II (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)	$110 after the prescription Drug deductible
Tier III drugs non-preferred Brand Name Drugs, drugs listed as Tier III Drugs or drugs not listed in the Essential Rx Drug List	$170 after the prescription Drug deductible
Preventive drugs and women's contraceptives*	$0 prescription drug deductible waived

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

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

Regardless of prescription drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name drugs, including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered Brand Name Drugs are subject to the applicable prescription drug deductible and 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, and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations, 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.

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.

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.

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 exceed 24 hours, whichever is less, 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% (deductible waived)
Orthotics (such as bracing, supports and casts)	20% (deductible waived)
Diabetic Equipment See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information.	20% (deductible waived)
Diabetic footwear	20% (deductible waived)
Prostheses	20% (deductible waived)

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)*	$45 (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)	$45 (deductible waived)
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	20%
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)*	$45 (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)	$45 (deductible waived)
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	20%

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)* ..... $45 (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 established by the administrator) ..... $45 (deductible waived)

Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center 20%

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.*

Home health services

Home health services (copayment required for each day home health visits occur) ..... 20% (deductible waived)

Calendar year maximum ..... *100 visits*

Other services

Sterilizations - Vasectomy* 20%

Sterilizations - Tubal ligation ..... $0 (deductible waived)

Blood, blood plasma, blood derivatives and blood factors ..... 20% (deductible waived)

Renal dialysis ..... 20% (deductible waived)

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.

**Deductible waived when services provided in an outpatient surgery setting.*

Infertility services

Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) 50%

Lifetime benefit maximum for Infertility services.....$10,000*

Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections. All calculations of the lifetime benefit maximum for all Infertility services are based on the total aggregate amount of benefits paid under this medical plan and all other Health Net of California, Inc. plans sponsored by the same employer. For the lifetime benefit maximum for infertility services, $8,500 applies to medical benefits and $1,500 applies to infertility drugs.

Infertility services are covered only for the Health Net member.

Injections for infertility are covered only when provided in connection with services that are covered by this plan.

Acupuncture services

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

Office visits .....$45 (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 certification has been obtained;
- Artificial insemination for reasons not related to infertility;
- 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;
- Conception by medical procedures (IVF 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's 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 certification for coverage;
- Hearing aids;
- Immunizations and injections for foreign travel/occupational purposes;
- 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;
- 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, a participating provider (medical), or the Behavioral Health Administrator according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;
- 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; and
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by Health Net (medical), the Administrator (Mental Disorders or Chemical Dependency) or when you require Emergency or Urgently Needed Care.

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 (California Code of Regulations, Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services.

You may contact Health Net at the number shown on the back cover, 7 days 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 certification 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 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 a participating provider (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 a participating provider (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency); otherwise, it will not be covered by Health Net.

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

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

Emergency Medical Condition *is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:*

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

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

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

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

MEDICALLY NECESSARY CARE

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

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 and deductibles, 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 and deductibles 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 or deductibles for the rest of the year for most services provided or authorized by Health Net.

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain 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 from an out-of-network provider for care other than emergency or urgently needed care, you are responsible for the cost of these services.

Remember, this plan only covers services that are provided by participating providers, except for emergency or urgent care. Consult the Health Net HSP Directory for a full listing of Health Net-participating providers.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by or through your participating provider will never be your responsibility.

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

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 participating provider.)

If you receive emergency or urgent care services not provided or directed by a participating provider, 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 or urgent care center report.

Please call the Health Net Customer Contact Center at the phone number on the back cover to obtain claim forms. 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.

REIMBURSEMENT DISCLOSURE

Health Net pays Participating Physicians and other professional Providers on a fee-for-service basis, according to an agreed Contracted Rate. Members may request more information about our payment methods by contacting Health Net's Customer Contact Center at the telephone number on the back of their Health Net ID card.

Facilities

Health care services for you and eligible members of your family will be provided by PureCare HSP participating providers.

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

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

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

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

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

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

In addition, you may request continued care from a provider, including a hospital, if you have been enrolled in another Health Net HSP 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 HSP 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 the deductible and copayments for any services and supplies received while your coverage is continued during the review process.

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

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

If you have a disagreement with our plan

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

If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

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

MEMBER GRIEVANCE AND APPEALS PROCESS

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

How to file a grievance or appeal:

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

You may also write to: *Health Net of California*
P.O. Box 10348
Van Nuys, CA 91410-0348

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

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

In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its participating 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 certification by the Behavioral Health Administrator in order to be covered. No prior certification 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 certification 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 C ode.

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 participating 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 participating providers 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 Brand Name Drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Essential Rx Drug List);
- 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; and
- Preventive drugs. and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- If a prescription drug deductible applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies, and preventive 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.
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations 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 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, and 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 provider;

- 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 participating provider 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 a participating provider, 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 a participating provider 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
Examination for Contact Lenses
Standard contact lens fit and follow-up ..... up to $55
Premium contact lens fit and follow-up ..... 10% off retail

Limitation:

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

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

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

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

Optional Lenses and Treatments including: $0

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

Premium Progressive Lenses $0

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

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

* Contact Lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:
  - High Ametropia exceeding -10D or +10D in meridian powers
  - Anisometropia of 3D in meridian powers
  - Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
  - Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

Medically Necessary Contact Lenses:
Coverage of Medically Necessary contact lenses is subject to Medical Necessity, Prior Certification 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

Except as described below, all of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. 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.

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

Selecting a dentist
Our dental plan makes it easy for you to choose a personal dental provider. When you enroll, you must select a dentist for your from our list of Primary Dentists for your area. To find a primary care dentist online:

Step 1: Go to www.healthnet.com. At the bottom of the page you will find a drop down for Health Net Dental, click on it and choose *California Commercial Health Plans*.

Step 2: The site will bring you to a Health Net Disclaimer page, click *Continue*.

Step 3: Now you have arrived at the Health Net Dental website. To locate a provider, you can click on *Locate Dentist* on the left hand side of the screen, or you can click on the first bullet in the body of the page *Dentist Locator.*

Step 4: Next, click on *HEALTH NET DHMO CA ONLY,* under the plan name options and choose a search criteria that best meets your needs.

Step 5: Next, enter the appropriate data to search.

Step 6: Once data is entered, just click *Submit* at the bottom of the page for the results of the search. You may change your primary dentist once a month. Primary dentist changes made prior to the 15th of the month are effective the first of the following month. Simply select a new dentist from the listing of primary dentists and call Health Net Dental's Customer Contact Center at 1-866-249-2382 with your change.

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

SCHEDULE OF COVERED DENTAL SERVICES

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation-established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation – problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation – new or established patient	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Charge
D0170	Re-evaluation – limited, problem focused (not post-operative visit) up to six times in a 3 month period and up to a maximum of 12 in a 12 month period	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient	No Charge
D0210	X-rays Intraoral – complete series (including bitewings) limited to once every 24 months	No Charge
D0220	X-rays Intraoral – periapical first film limited to a maximum of 20 periapicals in a 12 month period	No Charge
D0230	X-rays Intraoral – periapical each additional film limited to a maximum of 20 periapicals in a 12 month period	No Charge
D0240	X-rays Intraoral – occlusal film limited to 2 in a 6 month period	No Charge
D0250	Extraoral – first film	No Charge
D0270	X-rays Bitewing – single film limited to once per date of service	No Charge
D0272	X-rays Bitewings – two films limited to once every 6 months	No Charge
D0273	X-rays Bitewings – three films	No Charge
D0274	X-rays Bitewings – four films – limited to once every 6 months	No Charge
D0277	Vertical bitewings – 7 to 8 films	No Charge

Code	Service	Member Co-payment
D0290	Posterior – anterior or lateral skull and facial bone survey radiographic image limited to a maximum of 3 per date of service	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No Charge
D0322	Tomographic survey limited to twice in a 12 month period	No Charge
D0330	Panoramic film limited to once in a 36 month period	No Charge
D0340	Cephalometric radiographic image limited to twice in a 12 month period	No Charge
D0350	Photograph 1st limited to a maximum of 4 per date of service	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Office visit fee – per visit (Unspecified diagnostic procedure, by report)	No Charge
Preventive		
D1110	Prophylaxis – adult limited to once in a 12 month period	No Charge
D1120	Prophylaxis – child limited to once in a 6 month period	No Charge
D1206	Topical fluoride varnish limited to once in a 6 month period	No Charge
D1208	Topical application of fluoride limited to once in a 6 month period	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant – per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1510	Space maintainer – fixed – unilateral limited to once per quadrant	No Charge
D1515	Space maintainer – fixed – bilateral	No Charge
D1520	Space maintainer – removable – unilateral limited to once per quadrant	No Charge

Code	Service	Member Co-payment
D1525	Space maintainer – removable – bilateral	No Charge
D1550	Re-cementation of space maintainer	No Charge
D1555	Removal of fixed space maintainer	No Charge
Restorative		
D2140	Amalgam – one surface, primary limited to once in a 12 month period	$25
D2140	Amalgam – one surface, permanent limited to once in a 36 month period	$25
D2150	Amalgam – two surfaces, primary limited to once in a 12 month period	$30
D2150	Amalgam – two surfaces, permanent limited to once in a 36 month period	$30
D2160	Amalgam – three surfaces, primary limited to once in a 12 month period	$40
D2160	Amalgam – three surfaces, permanent limited to once in a 36 month period	$40
D2161	Amalgam – four or more surfaces, permanent limited to once in a 12 month period	$45
D2161	Amalgam – four or more surfaces, permanent limited to once in a 36 month period	$45
D2330	Resin-based composite – one surface, anterior, primary limited to once in a 12 month period	$30
D2330	Resin-based composite – one surface, anterior, permanent limited to once in a 36 month period	$30
D2331	Resin-based composite – two surfaces, anterior primary limited to once in a12 month period	$45
D2331	Resin-based composite – two surfaces, anterior permanent limited to once in a 36 month period	$45
D2332	Resin-based composite – three surfaces, anterior primary limited to once in a 12 month period	$55
D2332	Resin-based composite – three surfaces, anterior permanent limited to once in a 36 month period	$55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) primary limited to once in a 12 month period	$60
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) permanent limited to cone in a 36 month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12 month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36 month period	$50
D2391	Resin-based composite – one surface, posterior primary limited to once in a 12 month period	$30

Code	Service	Member Co-payment
D2391	Resin-based composite – one surface, posterior permanent limited to once in a 36 month period	$40
D2392	Resin-based composite – two surfaces, posterior, primary limited to once in a 12 month period	$40
D2392	Resin-based composite – two surfaces, posterior; permanent limited to once in a 36 month period	$40
D2393	Resin-based composite – three surfaces, posterior; primary limited to once in a 12 month period	$50
D2393	Resin-based composite – three surfaces, posterior, permanent limited to once in a 36 month period	$50
D2394	Resin-based composite – four or more surfaces, posterior; primary limited to cone in a 12 month period	$70
D2394	Resin-based composite – four or more surfaces, posterior; permanent limited to once in a 36 month period	$70
Crowns – Single Restorations Only		
D2710	Crown – Resin-based composite (indirect) limited to once in a 5 year period	$140
D2712	Crown – 3/4 resin-based composite (indirect) limited to once in a 5 year period	$190
D2721	Crown – Resin with predominantly base metal limited to once in a 5 year period	$300
D2740	Crown – porcelain/ceramic substrate limited to once in a 5 year period	$300
D2751	Crown – porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D2781	Crown – 3/4 cast predominantly base metal limited to once in a 5 year period	$300
D2783	Crown – 3/4 porcelain/ceramic limited to once in a 5 year period	$310
D2791	Crown – full cast predominantly base metal limited to once in a 5 year period	$300
D2910	Recement inlay, onlay, or partial coverage restoration limited to once in a 12 month period	$25
D2915	Recement cast or prefabricated post and core	$25
D2920	Recement crown	$25
D2929	Prefabricated porcelain/ceramic crown – primary tooth limited to once in a 12 month period	$95
D2930	Prefabricated stainless steel crown – primary tooth limited to once in a 12 month period	$65

Code	Service	Member Co-payment
D2931	Prefabricated stainless steel crown – permanent tooth limited to once in a 36 month period	$75
D2932	Prefabricated Resin Crown, primary limited to once in a 12 month period	$75
D2932	Prefabricated Resin Crown, permanent limited to once in a 36 month period	$75
D2933	Prefabricated Stainless steel crown resin window, primary limited to once in a 12 month period	$80
D2933	Prefabricated Stainless steel crown resin window, permanent limited to once in a 36 month period	$80
D2940	Protective restoration limited to once per tooth in a 12 month period	$25
D2950	Core buildup, including any pins	$20
D2951	Pin retention – per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post – same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post – same tooth	$35
D2971	Additional procedures to construct new crown under existing partial dental framework	$35
D2980	Crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration) limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) – anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55

Code	Service	Member Co-payment
D3310	Root canal therapy, Anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195
D3320	Root canal therapy, Bicuspid (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Root canal therapy, Molar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy – anterior	$240
D3347	Retreatment of previous root canal therapy – bicuspid	$295
D3348	Retreatment of previous root canal therapy – molar	$365
D3351	Apexification/recalcification – initial visit limited to once per permanent tooth	$85
D3352	Apexification/recalcification – interim only following D3351. Limited to once per permanent tooth	$45
D3410	Apicoectomy/periradicular surgery – permanent anterior teeth only	$240
D3421	Apicoectomy/periradicular surgery – permanent bicuspid (first root) teeth only	$250
D3425	Apicoectomy/periradicular surgery – permanent 1st and 2nd molar teeth only molar (first root)	$275
D3426	Apicoectomy/periradicular surgery (each additional root) permanent teeth only	$110
D3430	Retrograde filling – per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	Gingivectomy or gingivoplasty – once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty – once per quadrant every 36 months	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – muco – gingival surgery – once per quadrant every 36 months	$265
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces – once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80

Code	Service	Member Co-payment
D4341	Periodontal scaling and root planing – four or more teeth – once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing – one to three teeth – once per quadrant every 24 months	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$10
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		
D5110	Complete denture – maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	$300
D5120	Complete denture – mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture-complete denture	$300
D5130	Immediate denture – maxillary	$300
D5140	Immediate denture – mandibular	$300
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$300
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$335
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) limited to once in a 5 year period	$335
D5410	Adjust complete denture – maxillary limited to once per date of services; twice in a 12 month period	$20
D5411	Adjust complete denture – mandibular limited to once per date of services; twice in a 12 month period	$20
D5421	Adjust partial denture – maxillary limited to once per date of services; twice in a 12 month period	$20
D5422	Adjust partial denture – mandibular limited to once per date of services; twice in a 12 month period	$20
D5510	Repair broken complete denture base limited to once per date of services; twice in a 12 month period	$40

Code	Service	Member Co-payment
D5520	Replace missing or broken teeth – complete denture (each tooth) limited to a maximum of four, per arch, per date of services; twice per arch in a 12 month period	$40
D5610	Repair resin denture base limited to once per arch per date of services; twice per arch in a 12 month period	$40
D5620	Repair cast framework limited to once per arch per date of services; twice per arch in a 12 month period	$40
D5630	Repair or replace broken clasp limited to a maximum of three, per date of service, twice per arch in a 12 month period	$50
D5640	Replace broken teeth – per tooth limited to a maximum of four, per arch, per date of services; twice per arch in a 12 month period	$35
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of services; once per tooth	$35
D5660	Add clasp to existing partial denture limited to a maximum of three, per date of service; twice per arch in a 12 month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12 month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12 month period	$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12 month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12 month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12 month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12 month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12 month period	$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12 month period	$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36 month period	$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36 month period	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture – Complete maxillary	$300
D5865	Overdenture – complete maxillary	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350

Code	Service	Member Co-payment
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification limited to twice in a 12 month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12 month period	$145
D5960	Speech aid prosthesis, modification limited to twice in a 12 month period	$145

Code	Service	Member Co-payment
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Topical Medicament Carrier	$70
D5999	Denture duplication	$350
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar – implant supported or abutment supported	$350
D6056	Prefabricated abutment – includes modification and placement	$135
D6057	Custom fabricated abutment – includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315

Code	Service	Member Co-payment
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330
D6077	Implants supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75

Code	Service	Member Co-payment
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
Fixed Prosthodontics		
D6211	Pontic – cast predominantly base metal limited to once in a 5 year period	$300
D6241	Pontic – porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6245	Pontic – porcelain/ceramic limited to once in a 5 year period	$300
D6251	Crown – resin with predominantly base metal limited to once in a 5 year period	$300
D6721	Crown – resin predominantly base metal – denture limited to once in a 5 year period	$300
D6740	Crown – porcelain/ceramic limited to once in a 5 year period	$300
D6751	Crown –porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6781	Crown – 3/4 cast predominantly base metal limited to once in a 5 year period	$300
D6783	Crown – 3/4 porcelain/ceramic limited to once in a 5 year period	$300
D6791	Crown – full cast predominantly base metal limited to once in a 5 year period	$300
D6930	Recement bridge	$40
D6980	Bridge repair, by report	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral and Maxillofacial Surgery		
D7111	Extraction, coronal remnants – deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$120
D7220	Removal of impacted tooth – soft tissue	$95
D7230	Removal of impacted tooth – partially bony	$145
D7240	Removal of impacted tooth – completely bony	$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$175
D7250	Surgical removal of residual tooth roots (requiring cutting of soft tissue and bone and closure)	$80

Code	Service	Member Co-payment
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Surgical access of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Biopsy of oral tissue – hard (bone, tooth) limited to removal of the specimen only; once per arch per date of services	$180
D7286	Biopsy of oral tissue – soft limited to removal of the specimen only, up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth; permanent teeth only, once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$85
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) limited to a once in a 5 year period per arch	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$180

Code	Service	Member Co-payment
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of palatal torus limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	Incision and drainage of abscess – intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess – extraoral soft tissue	$70
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of services	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of services	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone limited to once per quadrant per date of services	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230

Code	Service	Member Co-payment
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus – closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrostomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350
D7875	Arthroscopy – surgical: synovectomy	$350
D7876	Arthroscopy – surgical: discectomy	$350
D7877	Arthroscopy – surgical: debridement	$350
D7880	Occlusal orthotic device, by report	$120

Code	Service	Member Co-payment
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure limited to once per arch per date of service	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue – per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350

Code	Service	Member Co-payment
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
Medically Necessary Orthodontics		
	Medically Necessary Banded Case	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
	Handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia	$15
D9223	Deep sedation/general anesthesia – each 15 minute increment	$45
D9230	Analgesia nitrous oxide	$15
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$60

Code	Service	Member Co-payment
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation – diagnostic service provided by dentist or physician (other than practitioner providing treatment)	$50
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20
D9440	Office visit – after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to a maximum of four injections per date of service	$20
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12 month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12 month period per quadrant	$45
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis-mounted case (D9950)	$210
D9999	Unspecified adjunctive procedure, by report	No Charge

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.

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

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

PEDIATRIC DENTAL CARE PROGRAM EXCLUSIONS AND LIMITATIONS

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

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

- Implant Services (D6000-D6199): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
- Medically Necessary Orthodontia (D8000-D8999): Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
  - Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
  - All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
  - Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
  - The automatic qualifying conditions are:
    - Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - A crossbite of individual anterior teeth causing destruction of soft tissue,
    - An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    - A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

    If a member does not score 26 or above nor meets one of the six automatic qualifying conditions, he/she may be eligible under the Early and Periodic Screening, Diagnosis and Treatment – Supplemental Services (EPSDT-SS) exception if medically necessity is documented.
- Adjunctive Services (D9000-D9999); Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;
  - Palliative treatment (relief of pain).
  - Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.
  - House/extended care facility calls, once per member per date of service.
  - One hospital or ambulatory surgical center call per day per provider per member.
  - Anesthesia for members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require Prior Authorization.

  - Occlusal guards when medically necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition.
- The following services, if in the opinion of the attending dentist or Health Net are not 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 could reasonably expect that a dental emergency situation did not exist.

ORTHODONTIC BENEFITS

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

Notice of language services

Health Net Life Insurance Company ("Health Net") complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:
On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Off Exchange 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or online at:
Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Online: healthnet.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800–537–7697).

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

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711). If you bought coverage through the California marketplace call 1-888-926-4988 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية أو اتصل على مركز الاتصال التجاري في 1-800-522-0088 (TTY: 711). في حال قمت بشراء التغطية من سوق كاليفورنيا، اتصل على الرقم 1-888-926-4988 (TTY: 711) وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من شركة التأمين على الحياة Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc., اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Եթե ապահովագրում եք գնել Կալիֆորնիայի շուկայական հրապարակի միջոցով, զանգահարեք 1-888-926-4988 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088（TTY：711）。如果您是透過加州健康保險交易市場購買承保，請致電 1-888-926-4988（TTY：711）。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi
बिना लागत वाली भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711) पर कॉल करें। यदि आपने कैलिफोर्निया मार्किट प्लैस के माध्यम से कवरेज खरीदा है तो 1-888-926-4988 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company पीपीओ PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc. के एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Kev pab, hu rau peb ntawm tus xov tooj teev nyob rau hauv koj daim ID card los yog hu rau 1-800-522-0088 (TTY: 711). Yog tias koj yuav kev pov hwm ntawm California marketplace hu 1-888-926-4988 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088、(TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイス（保険購入サイト）を通じて保険を購入された方は、1-888-926-4988 (TTY: 711) までお電話ください。さらに援助が必要な場合：Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បើសិនអ្នកបានទិញការធានារ៉ាប់រងតាមរយៈ ទីផ្សារនៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទូរសព្ទទៅលេខ 1-888-926-4988 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO ពីក្រុមហ៊ុនធានារ៉ាប់រងជីវិត Health Net Life Insurance Company សូមទាក់ទងទៅនាយកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net of California, Inc. នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나1-800-522-0088 (TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스를 통해 보험을 구입하셨으면 1-888-926-4988 (TTY: 711)번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-522-0088 (TTY: 711). California marketplace hoolyéhíjí béeso ách'áąáh naanilí ats'íís baa áháyą biniiyé nahínił-nii'go éí kojį' hólne' 1-888-926-4988 (TTY: 711). Shíká anáá'doowoł jinízingo: PPO éí doodaii' EPOǫjí Health Net Life Insurance Company wolyéhíjí béeso ách'áąáh naa'nil biniiyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'į' hojilnih 1-800-927-4357. HMO éí doodaii' HSPǫjí Health Net of California, Inc.ǫjí béeso ách'áąáh naa'nil biniiyé hats'íís bik'é'ésti'go éí kojį' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند.
برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی
1-800-522-0088 (TTY: 711) تماس بگیرید. اگر پوشش بیمه را از طریق بازارگاه کالیفرنیا خریداری کردید با شماره
1-888-926-4988 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی
Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس
بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc. عضویت دارید، با خط راهنمایی تلفنی
DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕੈਲੀਫ਼ੋਰਨੀਆਂ ਮਾਰਕਿਟ ਪਲੇਸ ਦੇ ਰਾਹੀਂ ਬੀਮਾ ਕਵਰੇਜ਼ ਖਰੀਦੀ ਹੈ ਤਾਂ 1-888-926-4988 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੇ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ Healh Net of California, Inc. ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика.
Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711). Если свою страховку вы приобрели на едином сайте по продаже медицинских страховок в штате Калифорния, звоните по телефону 1-888-926-4988 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния (CA Dept. of Insurance), телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания DMHC, телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el Centro de Comunicación Comercial de Health Net, al 1-800-522-0088 (TTY: 711). Si adquirió la cobertura a través del mercado de California, llame al 1-888-926-4988 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711). Kung bumili kayo ng pagsakop sa pamamagitan ng California marketplace tawagan ang 1-888-926-4988 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) หากคุณซื้อความคุ้มครองผ่านทาง California marketplace โทร 1-888-926-4988 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`âu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711). Nếu quý vị mua khoản bao trả thông qua thị trường California 1-888-926-4988 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đ`ng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.

CONTACT US

For more information, please contact us at:

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

Customer Contact Center

Small Business Group:
1-800-522-0088 (English) TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

SBID: 86712