Small Business Group Ancillary

Exclusions *and* Limitations

Effective November 1, 2012

Dental HMO limitations

General

1. Any procedures not specifically listed as a covered benefit in this Plan's Schedule of Benefits are available at 75% of the usual and customary fees of the treating Health Net Dental selected general or specialty care dentist, provided the services are included in the treatment plan and are not specifically excluded.
2. Dental procedures or services performed solely for cosmetic purposes or solely for appearance are available at 75% of the usual and customary fees of the treating Health Net Dental selected general or specialty care dentist, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits.
3. General anesthesia is a covered benefit only when administered by the treating dentist, in conjunction with oral and periodontal surgical procedures.

Preventive

1. Routine cleanings (prophylaxis), periodontal maintenance services and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the copayment listed on this Plan's Schedule of Benefits. Additional prophylaxis are available, if medically necessary.
2. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption, unless medically necessary.

Diagnostic

1. Panoramic or full-mouth X-rays: Once every three (3) years, unless medically necessary.

Restorative

1. An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
2. Replacement of any crowns or fixed bridges (per unit) is limited to once every five (5) years.
3. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require an additional $125 copayment per unit in addition to the specified copayment for each crown/bridge unit.
4. There is a $75 copayment per crown/bridge unit in addition to the specified copayment for porcelain on molars.

Prosthodontics

1. Relines are limited to one (1) every twelve (12) months.
2. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a Health Net Plan, unless due to the loss of a natural functioning tooth. Replacements will be a benefit under this Plan only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the treating Health Net Dental selected general dentist.
3. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.

Endodontics

1. The copayments listed for endodontic procedures do not include the cost of the final restoration.

Oral surgery

1. The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists; however, it is available at 75% of your Health Net Dental selected general or specialty care dentist's usual and customary fees.

Dental HMO general exclusions

1. Services performed by any dentist not contracted with Health Net Dental, without prior approval by Health Net Dental (except out-of-area emergency services). This includes services performed by a general dentist or specialty care dentist.
2. Dental procedures started prior to the member's eligibility under this Plan or started after the member's termination from the Plan. Examples include: teeth prepared for crowns, root canals in progress, and full or partial dentures for which an impression has been taken.
3. Any dental services or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the Health Net Dental selected general dentist.
4. Orthognathic surgery.
5. Inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
6. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse or neglect.
7. Treatment of malignancies, cysts or neoplasms, unless specifically listed as a covered benefit on this Plan's Schedule of Benefits. Any services related to pathology laboratory fees.
8. Procedures, appliances or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital, developmental or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Benefits.
9. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
10. Dental services provided for or paid by a federal or state government agency or authority, political subdivision or other public program other than Medicaid or Medicare.
11. Dental services required while serving in the armed forces of any country or international authority.
12. Dental services considered experimental in nature.
13. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member.

Orthodontic exclusions and limitations

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the member will be responsible for all costs associated with any orthodontic treatment.

If you terminate coverage from the Health Net Plan after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

1. Orthodontic treatment must be provided by a Health Net Dental selected general dentist or Health Net Dental contracted orthodontist in order for the copayments listed in this Plan's Schedule of Benefits to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.
3. The following are not included as orthodontic benefits:
   - A. Repair or replacement of lost or broken appliances;
   - B. Retreatment of orthodontic cases;
   - C. Treatment involving:
     - i. Maxillofacial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
     - ii. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
     - iii. Treatment related to temporomandibular joint disorders;
     - iv. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
4. The retention phase of treatment shall include the construction, placement and adjustment of retainers.
5. Active orthodontic treatment in progress on your effective date of coverage is not covered. Active orthodontic treatment means tooth movement has begun.

Classic Plus 1 plan

General exclusions

A. Dental services that are not necessary.

B. Hospitalization or other facility charges.

C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any dental procedure not directly associated with dental disease.

F. Any dental procedure not performed in a dental setting.

G. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

H. Any implant procedures performed which are not listed as covered implant procedures in the Schedule of Covered Dental Services.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by worker's compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

M. Replacement of complete dentures, and fixed and removable partial dentures or crowns and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient noncompliance, the patient is liable for the cost of replacement.

N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.

O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

P. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

Q. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.

R. Attachments to conventional removable prostheses or fixed bridgework. This includes semiprecision or precision attachments associated with partial dentures, crowns or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

V. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.

W. Dental services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the policy terminates.

X. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Y. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Z. In the event that a non-network dentist routinely waives copayments and/or the deductible for a particular dental service, the dental service for which the copayments and/or deductible are waived is reduced by the amount waived by the non-network provider.

AA. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

BB. Any dental services or procedures not listed in the Schedule of Covered Dental Services.

General limitations

1. Bacteriologic cultures.
2. Viral cultures.
3. Intraoral bitewing radiographs. Limited to 1 series of films per calendar year.
4. Panorex radiographs. Limited to 1 time per consecutive 36 months.
5. Oral/facial photographic images. Limited to 1 time per consecutive 36 months.
6. Diagnostic casts. Limited to 1 time per consecutive 24 months.
7. Extraoral radiographs. Limited to 2 films per calendar year.
8. Intraoral – complete series (including bitewings). Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.
9. Intraoral periapical radiographs.
10. Pulp vitality tests. Limited to 1 charge per visit, regardless of how many teeth are tested.
11. Intraoral occlusal film.
12. Periodic oral evaluation. Limited to 2 times per consecutive 12 months.
13. Comprehensive oral evaluation. Limited to 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.
14. Limited or detailed oral evaluation. Limited to 2 times per consecutive 12 months. Only 1 exam is covered per date of service.
15. Comprehensive periodontal evaluation – new or established patient. Limited to 2 times per consecutive 12 months.
16. Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. Limited to 1 time per consecutive 12 months.
17. Dental prophylaxis. Limited to 2 times per consecutive 12 months.
18. Fluoride treatments – child. Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
19. Sealants. Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
20. Space maintainers. Limited to covered persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
21. Re-cement space maintainers. Limited to 1 per consecutive 6 months after initial insertion.
22. Amalgam restorations. Multiple restorations on one surface will be treated as a single filling.
23. Composite resin restorations – anterior. Multiple restorations on one surface will be treated as a single filling.
24. Gold foil restorations. Multiple restorations on one surface will be treated as a single filling.
25. Apexification. Limited to 1 time per tooth per lifetime.
26. Apicoectomy and retrograde filling. Limited to 1 time per tooth per lifetime.
27. Hemisection. Limited to 1 time per tooth per lifetime.
28. Root canal therapy. Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.
29. Retreatment of previous root canal therapy. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.
30. Root resection/amputation. Limited to 1 time per tooth per lifetime.
31. Therapeutic pulpotomy. Limited to 1 time per primary or secondary tooth per lifetime.
32. Pulpal therapy (resorbable filling) – anterior or posterior, primary tooth (excluding final restoration). Limited to 1 time per tooth per lifetime. Covered for anterior or posterior teeth only.
33. Pulp caps – direct/indirect – excluding final restoration. Not covered if utilized solely as a liner or base underneath a restoration.
34. Pulpal debridement, primary and permanent teeth. Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.
35. Crown lengthening. Limited to 1 per quadrant or site per consecutive 36 months.
36. Gingivectomy/gingivoplasty. Limited to 1 per quadrant or site per consecutive 36 months.
37. Gingival flap procedure. Limited to 1 per quadrant or site per consecutive 36 months.
38. Osseous graft. Limited to 1 per quadrant or site per consecutive 36 months.
39. Osseous surgery. Limited to 1 per quadrant or site per consecutive 36 months.
40. Guided tissue regeneration. Limited to 1 per quadrant or site per consecutive 36 months.
41. Soft tissue surgery. Limited to 1 per quadrant or site per consecutive 36 months.
42. Periodontal maintenance. Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
43. Full mouth debridement. Limited to once per consecutive 36 months.
44. Provisional splinting. Cannot be used to restore vertical dimension or as part of full mouth rehabilitation; should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.
45. Scaling and root planing. Limited to 1 time per quadrant per consecutive 24 months.

46. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report. Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.
47. Alveoloplasty.
48. Biopsy. Limited to 1 biopsy per site per visit.
49. Frenectomy/frenuloplasty.
50. Surgical incision. Limited to 1 per site per visit.
51. Removal of a benign cyst/lesion. Limited to 1 per site per visit.
52. Removal of torus. Limited to 1 per site per visit.
53. Root removal, surgical. Limited to 1 time per tooth per lifetime.
54. Simple extractions. Limited to 1 time per tooth per lifetime.
55. Surgical extraction of erupted teeth or roots. Limited to 1 time per tooth per lifetime.
56. Surgical access, surgical exposure, or immobilization of unerupted teeth. Limited to 1 time per tooth per lifetime.
57. Primary closure of a sinus perforation. Limited to 1 per tooth per lifetime.
58. Placement of device to facilitate eruption of impacted tooth. Limited to 1 time per tooth per lifetime.
59. Transseptal fiberotomy/supracrestal fiberotomy, by report. Limited to 1 time per tooth per lifetime.
60. Vestibuloplasty. Limited to 1 time per site per consecutive 60 months.
61. Bone replacement graft for ridge preservation – per site. Limited to 1 per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.
62. Excision of hyperplastic tissue or pericoronal gingiva. Limited to 1 per site per consecutive 36 months.
63. Appliance removal (not by dentist who placed appliance) includes removal of arch bar. Limited to once per appliance per lifetime.
64. Tooth reimplantation and/or transplantation services. Limited to 1 per site per lifetime.
65. Oroantral fistula closure. Limited to 1 per site per visit.
66. Analgesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
67. Desensitizing medicament.
68. General anesthesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
69. Local anesthesia. Not covered in conjunction with operative or surgical procedure.
70. Intravenous sedation and analgesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
71. Therapeutic drug injection, by report; other drugs and/or medicaments, by report. Limited to 1 per visit.
72. Occlusal adjustment.
73. Occlusal guards. Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
74. Occlusal guard reline and repair. Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
75. Occlusion analysis – mounted case. Limited to 1 time per consecutive 60 months.
76. Palliative treatment. Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.
77. Consultation not covered if done with exams or professional visit.
78. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.
79. Coping. Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on the same tooth.
80. Crowns – retainers/abutments. Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
81. Crowns – restorations. Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
82. Temporary crowns – restorations. Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
83. Inlays/onlays – retainers/abutments. Limited to 1 time per tooth per 60 consecutive months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
84. Inlays/onlays – restorations. Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
85. Pontics. Limited to 1 time per tooth per consecutive 60 months.
86. Retainer-cast metal for resin-bonded fixed prosthesis. Limited to 1 time per tooth per consecutive 60 months.
87. Pin retention. Limited to 2 pins per tooth; not covered in addition to cast restoration.
88. Post and cores. Covered only for teeth that have had root canal therapy.
89. Re-cement inlays/onlays, crowns, bridges and post and core. Limited to those performed more than 12 months after the initial insertion.
90. Sedative filling. Covered as a separate benefit only if no other service, other than X-rays and exam, were done on the same tooth during the visit.
91. Stainless steel crowns. Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown – primary tooth, are limited to primary anterior teeth.

92. Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.

93. Fixed partial dentures (bridges). Limited to 1 time per tooth per consecutive 60 months.

94. Full dentures. Limited to 1 per consecutive 60 months. No additional allowances for precision or semiprecision attachments.

95. Partial dentures. Limited to 1 per consecutive 60 months. No additional allowances for precision or semiprecision attachments.

96. Relining and rebasing dentures. Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

97. Tissue conditioning – maxillary or mandibular. Limited to 1 time per consecutive 12 months.

98. Repairs or adjustments to full dentures, partial dentures, bridges or crowns. Limited to repairs or adjustments performed more than 12 months after the initial insertion.

99. Replacement of implants, implant crowns, implant prosthesis, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.

100. Implant placement. Limited to 1 time per consecutive 60 months.

101. Implant supported prosthetics. Limited to 1 time per consecutive 60 months.

102. Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis. Limited to 1 time per consecutive 12 months.

103. Repair implant supported prosthesis, by report. Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.

104. Abutment supported crown (titanium) or retainer crown for FPD – titanium. Limited to 1 time per consecutive 60 months.

105. Repair implant abutment, by report. Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.

106. Implant removal, by report. Limited to 1 time per consecutive 60 months.

107. Radiographic/surgical implant index, by report. Limited to 1 time per consecutive 60 months.

108. Orthodontic services. Services or supplies furnished by a dentist to a covered person in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.

109. Appliance therapy, fixed or removable. Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances and any fixed or removable interceptive orthodontic appliances.

110. Cephalometric film. Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.

111. Any required copayment, deductible waiting period or maximum benefit is waived for a covered person in their 2nd or 3rd trimester of pregnancy of the following covered dental services: prophylaxis, scaling and root planing, periodontal maintenance, and full-mouth debridement.

Classic Plus 2, Classic, Essential and Essential Value plans

General exclusions

A. Dental services that are not necessary.

B. Hospitalization or other facility charges.

C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any dental procedure not directly associated with dental disease.

F. Any dental procedure not performed in a dental setting.

G. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

H. Placement of dental implants, implant-supported abutments and prostheses.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by worker's compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

M. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient noncompliance, the patient is liable for the cost of replacement.

N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.

O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

P. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

R. Attachments to conventional removable prostheses or fixed bridgework. This includes semiprecision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

V. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.

W. Dental services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the policy terminates.

X. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Y. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Z. In the event that a non-network dentist routinely waives copayments and/or the deductible for a particular dental service, the dental service for which the copayments and/or deductible are waived is reduced by the amount waived by the non-network provider.

AA. Foreign services are not covered unless required as an emergency.

BB. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

CC. Any dental services or procedures not listed in the Schedule of Covered Dental Services.

General limitations

1. Dental services are covered at the least costly, clinically accepted treatment. (Posterior composites and gold foil restorations are automatically alt benefited to amalgam fillings; high noble crowns and pontics are automatically alt benefited to noble crowns and pontics.)

2. Oral evaluations (ADA codes D0120-D0180) are covered as a separate benefit only if no other service was done during the visit other than prophy and X-rays. Limited to 2 times per 12 consecutive months.

3. Intraoral-complete series, vertical bitewings and panorex radiographs (ADA codes D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Exception to the 36-month limit on panorex radiographs will be made if taken for diagnosis of third molars, cysts or neoplasms.

4. Extraoral radiographs (ADA codes D0250 and D0260) are limited to 2 films per plan year.

5. Bitewing radiographs (ADA codes D0270, D0272, D0273 and D0274) are limited to 1 series of films per plan year.

6. Cephalometric film (ADA code D0340) is limited to 1 per consecutive 12 months and can only be billed for orthodontics.

7. Oral/facial photographic images (ADA code D0350) is limited to 1 time per consecutive 36 months.

8. Oral cancer screening (Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytoloty or biopsy procedures) (ADA code D0431) is limited to 1 time per consecutive 12 months.

9. Pulp vitality testing (ADA code D0460) is limited to 1 charge per visit regardless of how many teeth are tested.

10. Dental prophylaxis (ADA codes D1110 and D1120) is limited to 2 times per 12 consecutive months.

11. Diagnostic casts (ADA code D0470) limited to 1 time per consecutive 24 months.

12. Fluoride treatment (ADA codes D1203 and D1206) limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months. Treatment should be done in conjunction with dental prophylaxis.

13. Sealants (ADA code D1351) limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.

14. Space maintainers (ADA codes D1510, D1515, D1520 and D1525) are limited to covered persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

15. Re-cement space maintainers (ADA code D1550) is limited to 1 per consecutive 6 months after initial insertion.

16. Multiple restorations on one surface (ADA codes D2140, D2330 and D2391) will be treated as a single filling.

17. Pin retention (ADA code D2951) limited to 2 pins per tooth; not covered in addition to cast restoration. (Cast restoration is defined as crowns, inlays and onlays.)

18. Inlays (ADA codes D2510–D2530, D2610–D2630, D2650–D2652) and onlays (ADA codes D2542–D2544, D2642–D2644, D2662 –D2664) are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.

19. Re-cement inlays/onlays, crowns, bridges and post and core. Limited to those performed more than 12 months after the initial insertion.

20. Crowns (ADA codes D2390, D2710–D2792, D2794, D2799, D2930–D2933, D6205, D6794 and D2970) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth.

21. Prefabricated esthetic coated stainless steel crown (ADA code D2934) is limited to primary anterior teeth and has a frequency limit of 1 per consecutive 60 months (tooth range C–H and M–R).

22. Posts and cores (ADA codes D2952–D2954, D2957, D6970, D6972, D6976–D6977) are covered only for teeth that have had root canal therapy.

23. Sedative fillings (ADA code D2940) are covered as a separate benefit only if no other service other than X-rays and exam were done on the same tooth during the visit.

24. Therapeutic pulpotomy (ADA code D3220) and pulpal therapy (resorbable filling) (ADA codes D3230 and D3240) are limited to 1 time per tooth per lifetime.

25. Pulpal debridement (ADA code D3221) is limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.

26. Root canal therapy (ADA codes D3310–D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.

27. Apicoectomy and retrograde filling (ADA codes D3410, D3421, D3425, D3426 and D3430), root resection/ amputation (ADA code D3450) and apexification (ADA codes D3351, D3352 and D3353) are limited to 1 time per tooth per lifetime.

28. Hemisection (ADA code D3920) is limited to 1 time per tooth per lifetime.

29. Scaling and root planing (ADA codes D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.

30. Localized delivery of antimicrobial agents (ADA code D4381) is limited to 3 per quadrant or 12 sites total for refractory pockets or in conjunction with periodontal scaling and root planing (ADA codes D4341 and D4342).

31. Periodontal maintenance (ADA code D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (ADA code D4355).

32. Complete dentures (ADA codes D5110 and D5120), immediate dentures (ADA codes D5130 and D5140), interim complete dentures (ADA codes D5810 and D5811) and overdenture–complete by report (ADA code D5860) are limited to 1 per consecutive 60 months.

33. Partial dentures (ADA codes D5211–D5281), interim partial dentures (ADA codes D5820 and D5821), fixed partial denture pontics (ADA codes D6210–D6253), fixed partial denture retainers-inlays/onlays (ADA codes D6545–D6634) and fixed partial denture retainer-crowns (ADA codes D6710–D6793) are limited to 1 per consecutive 60 months. There are no additional allowances for precision or semiprecision attachments (ADA codes D5862–D5867, D6950).

34. Relining and rebasing dentures (ADA codes D5710–D5761) is limited to relining/rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months.

35. Repairs and adjustments to full dentures (ADA codes D5410, D5411, D5510 and D5520) or partial fixed or removable dentures (ADA codes D5421, D5422, D5610–D5671, D6930 and D6980) are limited to those done more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

36. Tissue conditioning – maxillary or mandibular (ADA codes D5850 and D5851) is limited to 1 per consecutive 12 months.

37. Oroantral fistula closure (ADA code D7260) is limited to 1 per site per visit.

38. Tooth reimplantation and/or transplantation services (ADA codes D3470, D7270 and D7272) is limited to 1 per site per lifetime.

39. Biopsy (ADA codes D7285–D7288) is limited to 1 biopsy per site per visit.

40. Vestibuloplasty (ADA codes D7340 and D7350) is limited to 1 time per site per consecutive 60 months.

41. Surgical incision (ADA codes D7510–D7560) is limited to 1 time per site per visit.

42. Palliative treatment (ADA code D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.

43. Occlusal guards (ADA code D9940) are covered only if prescribed to control habitual grinding and are limited to 1 guard per consecutive 36 months. Occlusal analysis – mounted case (ADA code D9950) is limited to 1 per consecutive 60 months.

44. Occlusal guard reline and repair (ADA code D9942) MUST be performed more than 6 months after initial insertion and is limited to 1 time per consecutive 12 months.

45. Full mouth debridement (ADA code 4355) is limited to 1 time per consecutive 36 months.

46. General anesthesia (ADA codes D9220–D9221, D9230, D9241, D9242 and D9248) is covered only when clinically necessary.

47. Osseous grafts (ADA codes D4260, D4261, D4265–D4267), with or without resorbable or non-resorbable GTR membrane placement (ADA codes D4245 and D4263), are limited to once every consecutive 36 months per quadrant or surgical site. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area are limited to once every 36 consecutive months. This includes gingivectomy or gingivoplasty (ADA codes D4210–D4211), gingival flap procedure (ADA codes D4240–D4241, D4245), osseous surgery (ADA codes D4260–D4261), pedicle grafts and free soft tissue grafts (ADA codes D4270–D4273, D4275–D4276), crown lengthening hard tissue (ADA code D4249), anatomical crown exposure (ADA codes D4230 and D4231), clinical crown lengthening (ADA code D4249), bone replacement graph (ADA code D4264), surgical revision procedure, per tooth (ADA code 4268), distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) (ADA code D4274), and provisional splinting (ADA codes D4320 and D4321).

48. Replacement of complete or partial dentures (fixed and removable) (ADA codes D5110–D5281, D6210–D6793), and crowns (ADA codes D2710–D2792), previously submitted for payment under the plan is limited to once every 60 consecutive months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances (D8210–D8220, D8692).

49. Removal of a benign cyst/lesion (ADA codes D7410–D7412, D7450–D7461) is limited to 1 per site per visit.

50. Removal of torus (ADA codes D7472 and D7473) is limited to 1 per site per visit.

51. Surgical access, surgical exposure or immobilization of unerupted teeth (ADA code D7280) is limited to 1 per site per lifetime.

52. Primary closure of a sinus perforation (ADA code D7261), placement of device to facilitate eruption of impacted tooth (ADA code D7283) and transseptal fiberotomy/ supracrestal fiberotomy, by report (ADA code D7291) are limited to 1 per tooth per lifetime.

53. Bone replacement graft for ridge preservation – per site (ADA code D7953) is limited to 1 per site per lifetime and is not covered if done in conjunction with other bone graft replacement procedures.

54. Excision of hyperplastic tissue or pericoronal gingivia (ADA codes D7970 and D7971) is limited to 1 per site per consecutive 36 months.

55. Appliance removal (not by the dentist who placed the appliance; includes removal of arch bar) (ADA code 7997) is limited to once per appliance per lifetime.

56. Coping (ADA codes D2975 and D6975) is limited to 1 per tooth per consecutive 60 months and is not covered if done at the same time as a crown on the same tooth.

57. Therapeutic drug injection, by report/other drugs and/or medicaments, by report (ADA codes D9610–D9630) are limited to 1 per site per visit.

58. Any required copayment, deductible waiting period or maximum benefit is waived for a covered person in their 2nd or 3rd trimester of pregnancy of the following covered dental services: prophylaxis, scaling and root planing, periodontal maintenance and full-mouth debridement.

59. Local anesthesia. Not covered in conjunction with operative or surgical procedure.

60. Consultation. Not covered if done with exams or professional visits.

Basic 500 plan

General exclusions

A. Dental services that are not necessary.

B. Hospitalization or other facility charges.

C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any dental procedure not directly associated with dental disease.

F. Any dental procedure not performed in a dental setting.

G. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

H. Placement of dental implants, implant-supported abutments and prostheses.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by worker's compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.

M. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.

N. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.

O. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

P. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

Q. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

R. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.

S. Dental services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date individual coverage under the policy terminates.

T. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.

U. Orthodontic services.

V. In the event that a non-network dentist routinely waives copayments and/or the deductible for a particular dental service, the dental service for which the copayments and/or deductible are waived is reduced by the amount waived by the non-network provider.

W. Foreign services are not covered unless required as an emergency.

X. Dental services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Y. Any dental services or procedures not listed in the Schedule of Covered Dental Services.

General limitations

1. Bacteriologic cultures.

2. Viral cultures.

3. Intraoral bitewing radiographs limited to 1 series of films per calendar year.

4. Panorex radiographs. Limited to 1 time per consecutive 36 months.

5. Oral/facial photographic images. Limited to 1 time per consecutive 36 months.

6. Diagnostic casts. Limited to 1 time per consecutive 24 months.

7. Extraoral radiographs. Limited to 2 films per calendar year.

8. Intraoral – complete series (including bitewings). Limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.

9. Intraoral periapical radiographs

10. Periodic oral evaluation. Limited to 2 times per consecutive 12 months.

11. Comprehensive oral evaluation. Limited to 2 times per consecutive 12 months. Not covered if done in conjunction with other exams.

12. Limited or detailed oral evaluation. Limited to 2 times per consecutive 12 months. Only 1 exam is covered per date of service.

13. Comprehensive periodontal evaluation – new or established patient. Limited to 2 times per consecutive 12 months.

14. Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. Limited to 1 time per consecutive 12 months.

15. Dental prophylaxis. Limited to 2 times per consecutive 12 months.
16. Fluoride treatments – child. Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
17. Sealants. Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
18. Space maintainers. Limited to covered persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
19. Re-cement space maintainers. Limited to 1 per consecutive 6 months after initial insertion.
20. Amalgam restorations. Multiple restorations on one surface will be treated as a single filling.
21. Composite resin restorations – anterior. Multiple restorations on one surface will be treated as a single filling.
22. Analgesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
23. Desensitizing medicament.
24. General anesthesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
25. Local anesthesia. Not covered in conjunction with operative or surgical procedure.
26. Intravenous sedation and analgesia. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary.
27. Therapeutic drug injection, by report; other drugs and/or medicaments, by report. Limited to 1 per visit.
28. Occlusal adjustment.
29. Occlusal guards. Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
30. Occlusal guard reline and repair. Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
31. Occlusion analysis – mounted case. Limited to 1 time per consecutive 60 months.
32. Palliative treatment. Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit. Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.
33. Any required copayment, deductible waiting period or maximum benefit is waived for a covered person in their 2nd or 3rd trimester of pregnancy of the following covered dental services: prophylaxis, scaling and root planing, periodontal maintenance and full-mouth debridement.

Vision – Preferred plans 1025-2 and 1025-3

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Any corrective eyewear, required by an employer as a condition of employment and safety eyewear, unless specifically covered under the policy.
4. Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.
5. Plano (nonprescription) lenses.
6. Nonprescription sunglasses.
7. Two pair of glasses in lieu of bifocals.
8. Services or materials provided by any other group benefit plans providing vision care.
9. Certain frame brands in which the manufacturer imposes a no-discount policy.

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

Limitation

Vision examination and vision materials – Fees charged by a provider for services other than vision examination or covered vision materials must be paid in full by the covered person to the provider. Such fees or materials are not covered under this policy.

Benefit allowances provide no remaining balance for future use within the same benefit period.

Vision – Preferred Value plan 10-2

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures.
3. Any vision examination.
4. Any eye, or vision examination, or any corrective eyewear, required by an employer as a condition of employment and safety eyewear, unless specifically covered under the policy.
5. Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.
6. Plano (nonprescription) lenses.
7. Nonprescription sunglasses.
8. Two pair of glasses in lieu of bifocals.
9. Services or materials provided by any other group benefit plans providing vision care.
10. Certain frame brands in which the manufacturer imposes a no-discount policy.

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

Limitation

Vision materials – Fees charged by a provider for services other than covered vision materials must be paid in full by the covered person to the provider. Such fees or materials are not covered under this policy.

Benefit allowances provide no remaining balance for future use within the same benefit period.

Chiropractic and acupuncture

Note: Employees are free to obtain care by self-referring to a participating acupuncturist or chiropractor. All covered services may require verification of Medical Necessity by American Specialty Health Plans of California (ASH Plans) Plans except for: (a) an initial examination by a participating acupuncturist or chiropractor, and (b) emergency/urgent acupuncture or chiropractic services.

Chiropractic

Exclusions and limitations

- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; and all chiropractic appliances except those specifically noted as covered or durable medical equipment.
- Education programs, non-medical lifestyle or self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Services or treatments delivered by a non-ASH Plans contracted provider, except for (a) emergency services; (b) urgent services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a member from a contracted provider within the service area.
- Adjunctive physiotherapy modalities and procedures unless provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Services, exams, (other than an initial examination to determine the appropriateness of chiropractic services), and/or treatments for conditions other than neuromusculoskeletal disorders or pain syndromes.
- Services provided by a chiropractor practicing outside California are not covered, except for emergency chiropractic services or urgent services.
- Any service or supply that is not permitted by state law with respect to the provider's scope of practice.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
- Auxiliary aids and services, including but not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services under anesthesia, or other related services.
- Services rendered in excess of visits or benefit maximums.
- Services, clinical laboratory studies, X-rays, supports and appliances, and other treatments or products that are classified as experimental or investigational.
- Any services or treatments that are furnished before the date the member becomes eligible or after the date the member ceases to be eligible under the member's plan.
- If the member's plan requires the member to obtain a primary care physician referral for chiropractic services, any chiropractic services or treatments furnished without the required primary care physician referral.
- Services or treatments that are not approved ASH Plans as medically necessary, in accordance with ASH Plans' Clinical Services Management Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) urgent services; and (c) emergency services.

For additional information, please contact Health Net at 1-800-361-3366.

This is only a summary. Additional exclusions and limitations apply. Please consult the plan's Evidence of Coverage, which is received after enrollment, for the exact terms and conditions of the coverage. Chiropractic and acupuncture services can be added to any of our Small Business HMO, Elect Open Access℠ or POS plans.

Acupuncture

Exclusions and limitations

- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Services, exams (other than an initial examination to determine the appropriateness of acupuncture services) and/or treatments for conditions other than neuromusculoskeletal disorders, nausea, pain or pain syndromes.
- Services or treatments delivered by a non-ASH Plans contracted provider, except for (a) emergency services; (b) urgent services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a member from a contracted provider within the service area.
- Services and other treatments that are classified as experimental or investigational.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
- Educational programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Services, examinations and/or treatments for asthma or addiction, such as nicotine addiction.
- Services and other treatments that are classified as experimental or investigational. If ASH Plans denies coverage for a therapy for a member who has a life-threatening or seriously debilitating condition based on a determination by ASH Plans that the therapy is experimental or investigational, the member may be able to request an independent medical review of ASH Plans' determination. The member should contact ASH Plans' Member Services Department at 1-800-678-9133 for more information.
- Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Any service or supply that is not permitted by state law with respect to the provider's scope of practice.

- Acupuncture performed with reusable needles.
- Services rendered in excess of visit or benefit maximums.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services provided by an acupuncturist practicing outside California, except for urgent services or emergency services.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any services or treatments that are furnished before the date the member becomes eligible or after the date the member ceases to be eligible under the member's plan.
- If the member's plan requires the member to obtain a primary care physician referral for acupuncture services, any acupuncture services or treatments furnished without the required primary care physician referral.
- Services or treatments that are not approved by ASH Plans as medically necessary, in accordance with ASH Plans' Clinical Services Management Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) urgent services; or (c) emergency services.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
- Adjunctive therapy not associated with acupuncture.

For additional information, please contact Health Net at 1-800-361-3366.

This is only a summary. Additional exclusions and limitations apply. Please consult the plan's Evidence of Coverage, which is received after enrollment, for the exact terms and conditions of the coverage. Chiropractic and acupuncture services can be added to any of our Small Business HMO, Elect Open Access, or POS plans.