

Individual & Family Plans
Covered California

Individual & Family HMO and HSP Plans

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Health Net®

This document is only a summary of your health coverage. You have the right to view the plan's *Plan Contract and Evidence of Coverage (EOC)* prior to enrollment. To obtain a copy of this document, contact your authorized Health Net agent or your Health Net sales representative at **1-877-609-8711**. The plan's *Plan Contract and EOC*, which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and the plan's *Plan Contract and EOC* thoroughly once you receive them, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices are included in this document to help you compare coverage benefits.

The coverage described in this Disclosure Form shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.

The benefits described under this Disclosure Form do not discriminate on the basis of race, ethnicity, nationality, gender, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition or exclusion period.

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

Please read this important notice about the Health Net HMO CommunityCare Network health plan service area and obtaining services from CommunityCare Network physician and hospital providers

Except for emergency care, benefits for physician and hospital services under this Health Net HMO CommunityCare Network (“CommunityCare Network”) plan are only available when you live in the CommunityCare Network service area and use a CommunityCare Network physician or hospital. When you enroll in this CommunityCare Network plan, you may

only use a physician or hospital who is in the CommunityCare Network and you must choose a CommunityCare Network primary care physician (PCP). You may obtain ancillary, pharmacy or Behavioral Health covered services and supplies from any Health Net participating ancillary, pharmacy or behavioral health provider.

Obtaining covered services under the Health Net HMO CommunityCare network plan

Type of provider	Hospital	Physician	Ancillary	Pharmacy	Behavioral health
Available from	¹ Only CommunityCare Network hospitals	¹ Only CommunityCare Network hospitals	All Health Net contracting ancillary providers	All Health Net participating pharmacies	All Health Net contracting behavioral health providers
<p>¹The benefits of this plan for physician and hospital services are only available for covered services received from a CommunityCare Network physician or hospital, except for (1) urgently needed care outside a 30-mile radius of your physician group and all emergency care; (2) referrals to non-CommunityCare Network providers are covered when the referral is issued by your CommunityCare Network physician group; and (3) covered services provided by a non-CommunityCare Network provider when authorized by Health Net.</p>					

The CommunityCare Network service area and a list of its physician and hospital providers are shown in the *Health Net CommunityCare Network Provider Directory* which is available online at www.healthnet.com. You can also contact Health Net’s Customer Contact Center at 1-877-609-8711 to request provider information. The *Health Net CommunityCare Network Provider Directory* is different from other Health Net provider directories.

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

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

- Health Net
- Health Net service area
- Hospital
- Member physician, participating physician group, primary care physician, physician, participating provider, contracting physician groups and contracting providers

- Network
- Provider Directory

If you have any questions about the CommunityCare Network service area, choosing your Community Care Network PCP, how to access specialist care or your benefits, please contact the Health Net Customer Contact Center at **1-877-609-8711**.

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 (“PureCare Network”) plan are only available when you live or work in the PureCare HSP 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 (PCP). 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	¹ Only PureCare Network hospitals	¹ Only PureCare Network physicians	All Health Net contracting ancillary providers	All Health Net participating pharmacies	All Health Net contracting behavioral health providers

¹The 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.

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 contact the Health Net Customer Contact Center at **1-877-609-8711** to request provider information. The *Health Net 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 brochure solely refers to the PureCare Network as explained above.

- Health Net
- Health Net service area
- Hospital
- Primary care physician, participating physician, physician, participating provider and contracting providers
- Network
- Provider Directory

If you have any questions about the PureCare Network service area, choosing a PCP, how to access care or your benefits, please contact the Health Net Customer Contact Center at **1-877-609-8711**.

Health Net individual & family coverage for you and your family

Health Net offers the following health care coverage options to individuals and families:

HMO – Our Individual & Family Plan Health Maintenance Organization (HMO) plans are designed for people who would like one doctor to coordinate their medical care at predictable costs. You are required to choose a main doctor – called a primary care physician (PCP) – from our CommunityCare HMO network. Your PCP oversees all of your health care and provides referral/authorization if specialty care is needed. When you choose one of our HMO plans, you may only use a physician or hospital that is in the Health Net CommunityCare Network.

HSP – Our Individual & Family Plan Health Care Service Plan (HSP) plans are designed for people who want to see any participating physician or health care professional without first obtaining a referral. You are required to choose a PCP from our PureCare HSP network, but you can go directly to any participating provider in our network at any time with no need for a referral. When you choose one of our HSP plans, you may only use a participating provider who is in the Health Net PureCare Network.

Is an HMO right for you?

With our HMO plans you are required to choose a PCP. Your PCP will provide and coordinate your medical care. You have the right to designate any PCP who participates in our Health Net CommunityCare network, has an office close enough your residence to allow reasonable access to medical care and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the PCP. Until you make your PCP designation, Health Net designates one for you. Information on how to select a PCP and a listing of the participating PCP's in the Health Net CommunityCare service area are available on the Health Net website at www.healthnet.com. You can also call **1-877-609-8711** to request provider information, or contact your Health Net authorized broker.

Your PCP oversees all your health care and provides the referral/authorization if specialty care is needed. PCPs include general and family practitioners, internists, pediatricians and OB/GYNs. Many services require only a fixed copayment from you. To obtain health care, simply present your ID card and pay the appropriate copayment.

Your PCP must first be contacted for initial treatment and consultation before you receive any care or treatment through a hospital, specialist, or other health care provider, except for OB/GYN visits, as set out below. All treatments recommended by such providers must be authorized by your PCP.

You do not need prior authorization from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who

specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. A listing of participating health care professionals who specialize in obstetrics or gynecology is available on the Health Net website at www.healthnet.com. You can also call **1-877-609-8711** to request provider information, or contact your Health Net authorized broker. Refer to the "Mental disorders and chemical dependency Services" section in this document for information about receiving care for mental disorders and chemical dependency.

Your PCP belongs to a larger group of health care professionals, called a participating physician group. If you need care from a specialist, your PCP refers you to one within this group.

Is an HSP right for you?

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 **1-877-609-8711** to request provider information, or contact your Health Net authorized broker. PCPs include general and family practitioners, internists, pediatricians and obstetricians/gynecologists.

Some of the covered expenses under the PureCare HSP plan are subject to a requirement of certification in order for a noncertification penalty to not apply. See the “Certification requirements for HSP plans only” on this page.

Calendar-year deductible

For some HMO and HSP plans, a calendar-year deductible is required for certain services and is applied to the out-of-pocket maximum. See the benefit grids for specific information. You must pay an amount of covered expenses for noted services equal to the calendar-year deductible before the benefits are paid by your plan. After the deductible is satisfied, you remain financially responsible for paying any other applicable copayments until you satisfy the individual or family out-of-pocket maximum. If you are a member in a family of two or more members, you reach the deductible either when you 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. For the HSP plans, penalties paid for services which were not certified as required do not apply to the yearly OOPM (see the “Certification requirements for HSP plans only” below). For the family OOPM to apply, you and your family must be enrolled as a family.

Certification requirements for HSP plans only

For the HSP plans, 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 authorization list from time to time. Any such changes

including additions and deletions from the prior authorization list will be communicated to participating providers and posted on the www.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 the Individual & Family Plan *Plan Contract and EOC* for your benefit plan for details.

Services that require certification include:

1. Inpatient admissions¹
Any type of facility, including but not limited to:
 - Acute rehabilitation center
 - Substance abuse facility
 - Hospice
 - Hospital
 - Behavioral health facility
 - Skilled Nursing Facility
2. Ambulance: non-emergency air or ground ambulance services
3. 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 authorization is required for determination of ongoing medical necessity
4. Chondrocyte implants
5. Cochlear implants
6. Clinical trials
7. Custom orthotics
8. Dermatology – inpatient procedures
 - Skin injections and implants
 - Dermabrasion/chemical peel
 - Laser treatment
 - Chemical exfoliation and electrolysis
9. Durable Medical Equipment:
 - Bone growth stimulator
 - Continuous positive airway pressure (CPAP)
 - Custom-made items
 - Hospital beds
 - Power wheelchairs
 - Scooters
10. Experimental/investigational services and new technologies.
11. Genetic testing
12. Home health care services including home uterine monitoring, hospice, nursing, occupational therapy, physical therapy, speech therapy, and tocolytic services
13. Neuro or spinal cord stimulator
14. Occupational and speech therapy.
15. Outpatient diagnostic procedures:
 - CT (Computerized Tomography)
 - MRA (Magnetic Resonance Imaging)
 - MRI (Magnetic Resonance Imaging)
 - Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
 - PET (Positron Emission Tomography)
 - Sleep studies

¹Certification 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.

16. 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.
17. Outpatient physical therapy and acupuncture (exceeding 12 visits).
18. Outpatient surgical procedures including:
 - Bariatric procedures
 - Blepharoplasty
 - Breast reductions and augmentations
 - Cleft palate reconstruction, including dental and orthodontic services
 - Mastectomy for gynecomastia
- Orthognathic procedures (includes TMJ treatment)
- Rhinoplasty
- Septoplasty
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
19. Prosthesis items exceeding \$2500 in billed charges
20. Radiation therapy
 - Intensity modulated radiation therapy (IMRT)
 - Proton beam therapy
 - Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)
21. Transplant related services
22. Transgender services
23. X-Stop

Timely access to non-emergency health care services

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

You may contact Health Net at the number shown on 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 Individual & Family Plan HMO or HSP Exchange *Plan Contract and EOC* or contact the Health Net Customer Contact Center at the phone number on the back cover.

Plan Overview – Health Net Platinum 90 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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

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

Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$4,000 single / \$8,000 family
Professional services	
Office visit copay ²	\$20
Specialist visit ²	\$40
Other practitioner office visit (including medically necessary acupuncture) ³	\$20
Preventive care services ^{2, 4}	\$0
X-ray and Diagnostic Imaging	\$40
Laboratory tests	\$20
Imaging (CT/PET scans, MRIs)	\$150
Rehabilitation and habilitation services	\$20
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	\$250
Hospital services	
Inpatient hospital stay (includes maternity)	\$250/day up to 5 days
Skilled nursing care	\$150/day up to 5 days
Emergency services	
Emergency room services (copayment waived if admitted)	\$150
Urgent care	\$40
Ambulance services (ground and air)	\$150
Mental/Behavioral health / Substance Use Disorder services⁵	
Mental/Behavioral health / Substance use disorder (inpatient)	\$250/day up to 5 days
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$20
Home health care services (100 visits per calendar year)	\$20
Other services	
Durable medical equipment	10%
Hospice service	\$0
Self-injectables (other than insulin) ⁶	10%
Prescription drug coverage^{7, 8, 9, 10}	
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$5 generic / \$15 preferred brand / \$25 non-preferred brand
Specialty drugs ¹¹	10%
Pediatric dental¹²	
Diagnostic and preventive services	\$0
Pediatric vision¹³	
Routine eye exam	\$0
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Plan Contract and EOC for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.

³Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

⁴Preventive 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

⁵Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

⁶Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

⁷Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

⁸If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

⁹Preventive 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

¹⁰The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com.

Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.

¹¹Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

¹²The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual and Family Plan Contract and EOC for details.

¹³The 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.

Plan Overview – Health Net Gold 80 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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

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

Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$6,250 single / \$12,500 family
Professional services	
Office visit copay ²	\$30
Specialist visit ²	\$50
Other practitioner office visit (including medically necessary acupuncture) ³	\$30
Preventive care services ^{2, 4}	\$0
X-ray and Diagnostic Imaging	\$50
Laboratory tests	\$30
Imaging (CT/PET scans, MRIs)	\$250
Rehabilitation and habilitation services	\$30
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	\$600
Hospital services	
Inpatient hospital stay (includes maternity)	\$600/day up to 5 days
Skilled nursing care	\$300/day up to 5 days
Emergency services	
Emergency room services (copayment waived if admitted)	\$250
Urgent care	\$60
Ambulance services (ground and air)	\$250
Mental/Behavioral health / Substance Use Disorder services⁵	
Mental/Behavioral health / Substance use disorder (inpatient)	\$600/day up to 5 days
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$30
Home health care services (100 visits per calendar year)	\$30
Other services	
Durable medical equipment	20%
Hospice service	\$0
Self-injectables (other than insulin) ⁶	20%
Prescription drug coverage^{7, 8, 9, 10}	
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$15 generic / \$50 preferred brand / \$70 non-preferred brand
Specialty drugs ¹¹	20%
Pediatric dental¹²	
Diagnostic and preventive services	\$0
Pediatric vision¹³	
Routine eye exam	\$0
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

- ¹ In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.
- ² Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.
- ³ Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.
- ⁴ 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.
- ⁵ Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
- ⁶ Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.
- ⁷ Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.
- ⁸ If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.
- ⁹ 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.
- ¹⁰ The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com. Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.
- ¹¹ Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.
- ¹² The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual and Family Plan Contract and EOC for details.
- ¹³ 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.

Plan Overview – Health Net Silver 70 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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

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

Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible ²	\$2,000 single / \$4,000 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$6,250 single / \$12,500 family
Professional services	
Office visit copay ³	\$45 (deductible waived)
Specialist visit ³	\$65 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture) ⁴	\$45 (deductible waived)
Preventive care services ^{3, 5}	\$0 (deductible waived)
X-ray and Diagnostic Imaging	\$65 (deductible waived)
Laboratory tests	\$45 (deductible waived)
Imaging (CT/PET scans, MRIs)	\$250 (deductible waived)
Rehabilitation and habilitation services	\$45 (deductible waived)
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	20% (deductible waived)
Hospital services	
Inpatient hospital stay (includes maternity)	20%
Skilled nursing care	20%
Emergency services	
Emergency room services (copayment waived if admitted)	\$250
Urgent care	\$90 (deductible waived)
Ambulance services (ground and air)	\$250
Mental/Behavioral health / Substance Use Disorder services⁶	
Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$45 (deductible waived)
Home health care services (100 visits per calendar year)	\$45 (deductible waived)
Other services	
Durable medical equipment	20% (deductible waived)
Hospice service	\$0 (deductible waived)
Self-injectables (other than insulin) ⁷	20%
Prescription drug coverage^{8, 9, 10, 11, 12}	
Brand-name calendar year deductible	\$250 per member / \$500 per family
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$15 generic / \$50 preferred brand / \$70 non-preferred brand
Specialty drugs ¹³	20%
Pediatric dental¹⁴	
Diagnostic and preventive services	\$0 (deductible waived)

Benefit description	Member(s) responsibility ¹
Pediatric vision¹⁵ Routine eye exam	\$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²For certain services and supplies under this plan, a calendar-year deductible applies, 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.

³Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.

⁴Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

⁵Preventive 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

⁶Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

⁷Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

⁸Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

⁹If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

¹⁰The brand-name prescription drug deductible (per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs. If you are a Member in a Family of two or more Members, you reach the Brand Name Drug Deductible either when you meet the amount for any

one Member, or when your entire Family reaches the Family amount. The brand-name prescription drug deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a participating pharmacy and preventive drugs and women's contraceptives. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

¹¹Preventive 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

¹²The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com. Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.

¹³Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

¹⁴The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual and Family Plan Contract and EOC for details.

¹⁵The 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.

Plan Overview – Health Net Silver 94 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible	None
Out-of-pocket maximum (Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$2,250 single / \$4,500 family
Professional services	
Office visit copay ²	\$3
Specialist visit ²	\$5
Other practitioner office visit (including medically necessary acupuncture) ³	\$3
Preventive care services ^{2, 4}	\$0
X-ray and Diagnostic Imaging	\$5
Laboratory tests	\$3
Imaging (CT/PET scans, MRIs)	\$50
Rehabilitation and habilitation services	\$3
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	10%
Hospital services	
Inpatient hospital stay (includes maternity)	10%
Skilled nursing care	10%
Emergency services	
Emergency room services (copayment waived if admitted)	\$25
Urgent care	\$6
Ambulance services (ground and air)	\$25
Mental/Behavioral health / Substance Use Disorder services⁵	
Mental/Behavioral health / Substance use disorder (inpatient)	10%
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$3
Home health care services (100 visits per calendar year)	\$3
Other services	
Durable medical equipment	10%
Hospice service	\$0
Self-injectables (other than insulin) ⁶	10%
Prescription drug coverage^{7, 8, 9, 10}	
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$3 generic / \$5 preferred brand / \$10 non-preferred brand
Specialty drugs ¹¹	10%
Pediatric dental¹²	
Diagnostic and preventive services	\$0
Pediatric vision¹³	
Routine eye exam	\$0
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Plan Contract and EOC for terms and conditions of coverage.

- ¹ In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.
- ² Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.
- ³ Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.
- ⁴ 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.
- ⁵ Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
- ⁶ Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.
- ⁷ Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.
- ⁸ If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.
- ⁹ 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.
- ¹⁰ The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com. Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.
- ¹¹ Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.
- ¹² The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual and Family Plan Contract and EOC for details.
- ¹³ 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.

Plan Overview – Health Net Silver 87 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible ²	\$500 single / \$1,000 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$2,250 single / \$4,500 family
Professional services	
Office visit copay ³	\$15 (deductible waived)
Specialist visit ³	\$20 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture) ⁴	\$15 (deductible waived)
Preventive care services ^{3, 5}	\$0
X-ray and Diagnostic Imaging	\$20 (deductible waived)
Laboratory tests	\$15 (deductible waived)
Imaging (CT/PET scans, MRIs)	\$100 (deductible waived)
Rehabilitation and habilitation services	\$15 (deductible waived)
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	15% (deductible waived)
Hospital services	
Inpatient hospital stay (includes maternity)	15%
Skilled nursing care	15%
Emergency services	
Emergency room services (copayment waived if admitted)	\$75
Urgent care	\$30 (deductible waived)
Ambulance services (ground and air)	\$75
Mental/Behavioral health / Substance Use Disorder services⁶	
Mental/Behavioral health / Substance use disorder (inpatient)	15%
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$15 (deductible waived)
Home health care services (100 visits per calendar year)	\$15 (deductible waived)
Other services	
Durable medical equipment	15% (deductible waived)
Hospice service	\$0 (deductible waived)
Self-injectables (other than insulin) ⁷	15%
Prescription drug coverage^{8, 9, 10, 11, 12}	
Brand-name calendar year deductible	\$50 per member / \$100 per family
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$5 generic / \$15 preferred brand / \$25 non-preferred brand
Specialty drugs ¹³	15%
Pediatric dental¹⁴	
Diagnostic and preventive services	\$0 (deductible waived)

Benefit description	Member(s) responsibility ¹
Pediatric vision¹⁵ Routine eye exam	\$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²For certain services and supplies under this plan, a calendar-year deductible applies, 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.

³Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.

⁴Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

⁵Preventive 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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⁷Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

⁸Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

⁹If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

¹⁰The brand-name prescription drug deductible (per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs. If you are a Member in a Family of two or more Members, you reach the Brand Name Drug Deductible either when you meet the amount for any

one Member, or when your entire Family reaches the Family amount. The brand-name prescription drug deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a participating pharmacy and preventive drugs and women's contraceptives. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

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¹³Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

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Plan Overview – Health Net Silver 73 HMO

CommunityCare HMO offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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

Benefit description	Member(s) responsibility ¹
Unlimited lifetime maximum.	
Plan maximums	
Calendar year deductible ²	\$1,600 single / \$3,200 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$5,200 single / \$10,400 family
Professional services	
Office visit copay ³	\$40 (deductible waived)
Specialist visit ³	\$50 (deductible waived)
Other practitioner office visit (including medically necessary acupuncture) ⁴	\$40 (deductible waived)
Preventive care services ^{3, 5}	\$0
X-ray and Diagnostic Imaging	\$50 (deductible waived)
Laboratory tests	\$40 (deductible waived)
Imaging (CT/PET scans, MRIs)	\$250 (deductible waived)
Rehabilitation and habilitation services	\$40 (deductible waived)
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	20% (deductible waived)
Hospital services	
Inpatient hospital stay (includes maternity)	20%
Skilled nursing care	20%
Emergency services	
Emergency room services (copayment waived if admitted)	\$250
Urgent care	\$80 (deductible waived)
Ambulance services (ground and air)	\$250
Mental/Behavioral health / Substance Use Disorder services⁶	
Mental/Behavioral health / Substance use disorder (inpatient)	20%
Mental/Behavioral health / Substance use disorder office visit (outpatient)	\$40 (deductible waived)
Home health care services (100 visits per calendar year)	\$40 (deductible waived)
Other services	
Durable medical equipment	20% (deductible waived)
Hospice service	\$0 (deductible waived)
Self-injectables (other than insulin) ⁷	20%
Prescription drug coverage^{8, 9, 10, 11, 12}	
Brand-name calendar year deductible	\$250 per member / \$500 per family
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$15 generic / \$35 preferred brand / \$60 non-preferred brand
Specialty drugs ¹³	20%
Pediatric dental¹⁴	
Diagnostic and preventive services	\$0 (deductible waived)

Benefit description	Member(s) responsibility ¹
Pediatric vision¹⁵ Routine eye exam	\$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²For certain services and supplies under this plan, a calendar-year deductible applies, 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.

³Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, copayment will apply for the nonpreventive services.

⁴Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

⁵Preventive 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

⁶Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

⁷Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

⁸Orally administered anti-cancer drugs will have a Copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

⁹If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

¹⁰The brand-name prescription drug deductible (per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs. If you are a Member in a Family of two or more Members, you reach the Brand Name Drug Deductible either when you meet the amount for any

one Member, or when your entire Family reaches the Family amount. The brand-name prescription drug deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a participating pharmacy and preventive drugs and women's contraceptives. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

¹¹Preventive 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

¹²The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com. Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.

¹³Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

¹⁴The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual and Family Plan Contract and EOC for details.

¹⁵The 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.

Plan Overview – Health Net Bronze 60 HSP

PureCare HSP offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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Benefit description	Member(s) responsibility ^{1, 2}
Unlimited lifetime maximum. Benefits are subject to a deductible as noted.	
Plan maximums	
Calendar year deductible ³	\$5,000 single / \$10,000 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$6,250 single / \$12,500 family
Professional services	
Office visit copay ⁴	visits 1-3 \$60 (deductible waived) / visits 4+ \$60 (deductible applies)
Specialist visit ⁴	\$70 (deductible applies)
Other practitioner office visit (including medically necessary acupuncture) ⁵	\$60 (deductible applies)
Preventive care services ^{4, 6}	\$0 (deductible waived)
X-ray and diagnostic imaging	30% (deductible applies)
Laboratory tests	30% (deductible applies)
Imaging (CT, PET scans, MRIs)	30% (deductible applies)
Rehabilitation and habilitation therapy	\$60 (deductible applies)
Outpatient services	
Outpatient surgery (includes facility fee and physician/surgeon fees)	30% (deductible applies)
Hospital services	
Inpatient hospital stay (includes maternity)	30% (deductible applies)
Skilled nursing care	30% (deductible applies)
Emergency services	
Emergency room services (copayment waived if admitted)	\$300 (deductible applies)
Urgent care	visits 1-3 \$120 (deductible waived) / visits 4+ \$120 (deductible applies)
Ambulance services (ground and air)	\$300 (deductible applies)
Mental/Behavioral health / Substance Use Disorder services⁷	
Mental/Behavioral health/Substance use disorder (inpatient)	30% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	visits 1-3 \$60 (deductible waived) / visits 4+ \$60 (deductible applies)
Home health care services (100 visits per calendar year)	30% (deductible applies)
Other services	
Durable medical equipment	30% (deductible applies)
Hospice service	\$0 (deductible waived)
Self-injectables ⁸ (other than insulin)	30% (deductible applies)
Prescription drug coverage^{9, 10, 11, 12}	
Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	\$15 generic / \$50 preferred brand / \$75 non-preferred brand (deductible applies)
Specialty drugs ¹³	30% (deductible applies)

Benefit description	Member(s) responsibility ^{1, 2}
Pediatric dental ¹⁴ Diagnostic and preventive services	\$0 (deductible waived)
Pediatric vision ¹⁵ Routine eye exam	\$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Plan Contract and EOC for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²Certain services require prior certification from Health Net. Without prior certification, an additional \$250 is applied. Refer to the Plan Contract and EOC for details.

³For certain services and supplies under this plan, including prescription drugs, a calendar year deductible applies, 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.

⁴Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, a copayment will apply for the nonpreventive services.

⁵Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

⁶Preventive 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 and B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC), and the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA). Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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⁸Self-injectable drugs (other than insulin) are considered specialty drugs, and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net.

⁹Orally administered anti-cancer drugs will have a copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

¹⁰If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

¹¹Preventive 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. 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

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¹³Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

¹⁴The pediatric dental benefits are provided by Health Net of California, Inc., and administered by Dental Benefit Providers of California, Inc., (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family Plan Contract and EOC for details.

¹⁵The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Plan Overview – Health Net Minimum Coverage HSP

PureCare HSP offered in Los Angeles, Orange, San Diego and parts of Riverside and San Bernardino counties

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Benefit description	Member(s) responsibility ^{1, 2}
Unlimited lifetime maximum. Benefits are subject to a deductible as noted.	
Plan maximums Calendar year deductible (also applies to prescription drugs and pediatric dental services) ³	\$6,600 single / \$13,200 family
Out-of-pocket maximum (Includes calendar year deductible. Payments for services and supplies not covered by this plan will not be applied to this calendar year out-of-pocket maximum.)	\$6,600 single / \$13,200 family
Professional services Office visit copay ⁴	visits 1-3 0% (deductible waived) / visits 4+ 0% (deductible applies)
Specialist visit ⁴	0% (deductible applies)
Other practitioner office visit (including medically necessary acupuncture) ⁵	0% (deductible applies)
Preventive care services ^{4, 6}	\$0 (deductible waived)
X-ray and diagnostic imaging	0% (deductible applies)
Laboratory tests	0% (deductible applies)
Imaging (CT, PET scans, MRIs)	0% (deductible applies)
Rehabilitation and habilitation therapy	0% (deductible applies)
Outpatient services Outpatient surgery (includes facility fee and physician/surgeon fees)	0% (deductible applies)
Hospital services Inpatient hospital stay (includes maternity)	0% (deductible applies)
Skilled nursing care	0% (deductible applies)
Emergency services Emergency room services (copayment waived if admitted)	0% (deductible applies)
Urgent care	visits 1-3 0% (deductible waived) / visits 4+ 0% (deductible applies)
Ambulance services (ground and air)	0% (deductible applies)
Mental/Behavioral health / Substance Use Disorder services⁷ Mental/Behavioral health/Substance use disorder (inpatient)	0% (deductible applies)
Mental/Behavioral health/Substance use disorder office visit (outpatient)	visits 1-3 0% (deductible waived) / visits 4+ 0% (deductible applies)
Home health care services (100 visits per calendar year)	0% (deductible applies)
Other services Durable medical equipment	0% (deductible applies)
Hospice service	0% (deductible applies)
Self-injectables ⁸ (other than insulin)	0% (deductible applies)
Prescription drug coverage^{9, 10, 11, 12} Prescription drugs (up to a 30-day supply obtained through a participating pharmacy)	0% (deductible applies)
Specialty drugs ¹³	0% (deductible applies)

Benefit description	Member(s) responsibility ^{1, 2}
Pediatric dental ¹⁴ Diagnostic and preventive services	\$0 (deductible applies)
Pediatric vision ¹⁵ Routine eye exam	\$0 (deductible waived)
Glasses (limitations apply)	1 pair per year

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Plan Contract and EOC* for terms and conditions of coverage.

¹In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost-sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost-sharing means copayments, including coinsurance and deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

²Certain services require prior certification from Health Net. Without prior certification, an additional \$250 is applied. Refer to the Plan Contract and EOC for details.

³For certain services and supplies under this plan, including prescription drugs and pediatric dental services, a calendar year deductible applies, 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.

⁴Prenatal, postnatal and newborn care office visits for preventive care, including preconception visits, are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, a copayment will apply for the nonpreventive services.

⁵Includes acupuncture visits, physical, occupational and speech therapy visits and other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Chiropractic services are not covered. Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage.

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⁹Orally administered anti-cancer drugs will have a copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

¹⁰If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

¹¹Preventive 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. 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. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name preventive drug or women's contraceptive 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 preventive drug or women's contraceptive is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

¹²The Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as nonformulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the list do require prior authorization from Health Net. Health Net will approve a drug not on the List at the Tier III copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information that is reasonably necessary and requested by Health Net to make the determination. For a copy of the Essential Rx Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com. Generic Drugs will be dispensed when a generic drug equivalent is available. Health Net will cover Brand Name drugs that have a generic equivalent at the Tier III copayment, when determined to be medically necessary.

¹³Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. 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.

¹⁴The pediatric dental benefits are provided by Health Net of California, Inc., and administered by Dental Benefit Providers of California, Inc., (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the Individual & Family Plan Contract and EOC for details.

¹⁵The pediatric vision services benefits are provided by Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

How to apply

To apply for a Health Net Individual & Family Plan, go to www.coveredca.com.

Important things to know about your medical coverage

Who is eligible?

To be eligible for a Health Net Individual & Family Plan, you must: (a) live in the Health Net CommunityCare HMO service area for an HMO plan or the PureCare HSP service area for an HSP plan; (b) be a citizen or national of the United States or an alien lawfully present in the United States; (c) not be incarcerated; and (d) apply for enrollment during an Open Enrollment period or during a special enrollment period as defined on this page. In addition, your spouse or domestic partner (see next page for definition), if under age 65, and your children to age 26 are eligible to enroll as dependents. The following persons are not eligible for coverage under this plan: (a) persons eligible for enrollment in a group plan with minimum essential coverage; (b) persons age 65 and older and eligible for Medicare benefits; (c) are incarcerated; and (c) persons eligible for Medi-Cal or other applicable state or federal program.

Open Enrollment takes place November 15, 2014 to February 15, 2015, inclusive, then annually, including in 2016, from October 15 to December 7, inclusive.

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Special enrollment periods

In addition to the Open Enrollment period, you are eligible to enroll in this plan within 60 days of certain events, including but not limited to the following:

- Lost coverage in a plan with minimum essential coverage (coverage becomes effective the first of the following month after loss of coverage), not including voluntary termination or loss due to non-payment of premiums;
- Lost medically needy coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium);
- Lost pregnancy-related coverage under Medicaid (not including voluntary termination or termination due to failure to pay premium);
- Gained or became a dependent;
- Were mandated to be covered as a dependent due to a valid state or federal court order;
- Were released from incarceration;
- Had the material provision of your health coverage contract substantially violated by your health coverage issuer;
- Gained access to new health benefit plans as a result of a permanent move;

- Were receiving services under another health benefit plan from a contracting provider who no longer participates in that health plan for any of the following conditions: (a) an acute or serious condition; (b) a terminal illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contract's termination date or the effective date of coverage for a newly covered member;
- Demonstrate to Covered California that you did not enroll in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage;
- Are a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code;
- Newly become a citizen or national of the United States or an alien lawfully present in the United States;
- Were not allowed to enroll in a Covered California plan due to the intentional, inadvertent or erroneous actions of Covered California;
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions; or
- Are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (you can change from one plan to another one time per month).

Domestic partner

Domestic partner is the subscriber's same-sex spouse if the subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the subscriber's registered domestic partner who meets all the requirements of Section 297 or 299.2 of the California Family Code.

How does the monthly billing work?

Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 60 days in advance. If there are changes to the Health Net Individual Plan HMO or HSP Exchange *Plan Contract and EOC*, including changes in benefits, you will be notified at least 30 days in advance.

Can benefits be terminated?

You may cancel your coverage at any time by giving Health Net written notice to Covered California. In such event, termination will be effective on the first day of the month following Covered California's receipt of your written notice to cancel. Health Net has the right to terminate your coverage individually for any of the following reasons:

- You do not pay your premium on time (Health Net will issue a 30-day prior notice of our right to terminate your coverage for non-payment of premium. The 30-day prior notice will be sent on or before the first day of the month for which premiums are due and will describe the 30-day grace period, which begins after the last day of paid coverage. If you do not pay your premiums by the first day of the month for which

premiums are due, Health Net can terminate your coverage after the 30-day grace period.) Subscribers and enrolled dependents who are receiving Advance Payment of the Premium Tax Credit have a three-month grace period in lieu of the 30-day grace period. This plan will provide coverage for all allowable claims for the first month of a three-month grace period for non-payment of subscription charges. However, Health Net may suspend your coverage and pend claims for services rendered by health care providers in the second and third month of the three-month grace period and may ultimately deny these claims unless subscription charges due for the term of coverage are paid in full by the end of the three-month grace period. If the entire amount of subscription charges due are paid before the end of the three-month grace period, coverage that was suspended will be reinstated to the last day of paid coverage. Providers whose claims are denied by Health Net may bill you for payment.

- You and/or your family member(s) cease being eligible (see the “Who is eligible?” section.)
- You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include: misrepresenting eligibility information about you or a dependent; presenting an invalid prescription or physician order; or misusing a Health Net member ID card (or letting someone else use it).

Health Net can terminate your coverage, together with all like policies, by giving 90 day’s written notice. Members are responsible for payment of any services received after termination of coverage at the provider’s

prevailing non-member rates. This is also applicable to members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage.

If you terminate coverage for yourself or any of your family members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

Can coverage be rescinded or cancelled for fraud or intentional misrepresentation of material fact?

When Health Net can rescind or cancel a plan contract:

Within the first 24 months of coverage Health Net may rescind the plan contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

Health Net may cancel a plan contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the plan contract.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

Cancellation of a plan contract

If the plan Contract is cancelled, you will be sent a notice of cancellation and cancellation will be effective upon the date the notice of cancellation is mailed.

Rescission of a plan contract

If the plan contract is rescinded, Health Net shall have no liability for the provision of coverage under the plan contract.

By signing the enrollment application, you represent that all responses are true, complete and accurate, to the best of your knowledge, and that should Health Net accept your enrollment application, the enrollment application will become part of the plan contract between Health Net and you.

By signing the enrollment application, you further agree to comply with the terms of the plan contract.

If after enrollment Health Net investigates your enrollment application information, Health Net must notify you of this investigation, the basis of the investigation and offer you an opportunity to respond.

If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net.

If the plan contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the termination that will:

1. Explain the basis of the decision and your appeal rights;
2. Clarify that all members covered under your coverage other than the individual whose coverage is rescinded may continue to remain covered;
3. Explain that your monthly premium will be modified to reflect the number of members that remain under the plan contract; and
4. Explain your right to appeal Health Net's decision to rescind coverage.

If the plan contract is rescinded:

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

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

Are there any renewal provisions?

Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 60 days in advance of any changes in fees. You will be notified 30 days in advance of any changes in benefits or contract provisions.

Does Health Net coordinate benefits?

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

What is utilization review?

Health Net makes medical care covered under our Individual & Family Plans subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care. Health Net bases the approval or denial of services on the following main procedures:

- Evaluation of medical services to assess medical necessity and appropriate level of care.
- Implementation of case management for long-term or chronic conditions.
- Review and authorization of inpatient admission and referrals to noncontracting providers.
- Review of scope of benefits to determine coverage.

If you would like additional information regarding Health Net's Utilization Review System, please call the Health Net's Customer Contact Center at **1-877-609-8711**.

Does Health Net cover the cost of participation in 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 to benefit the member and the trial has therapeutic intent. For further information, please refer to the *Plan Contract and Evidence of Coverage*.

What if I have a disagreement with Health Net?

Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, or subject to or received an adverse benefit determination may file a grievance or appeal. An adverse benefit determination includes: (a) rescission of coverage, even if it does not have an adverse effect on a particular benefit at the time; (b) determination of an individual's eligibility to participate in this Health Net plan; (c) determination that a benefit is not covered; (d) an exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source of injury exclusion; or, (e) determination that a benefit is experimental, investigational, or not medically necessary or appropriate. In addition, plan members can request an Independent Medical Review of disputed health care services from the Department of Managed Health Care if they believe that health care services eligible for coverage and payment under their Health Net plan were improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies a member's appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, members can request an Independent Medical Review of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the *Plan Contract and Evidence of Coverage*.

Members not satisfied with the results of the appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. As a condition of enrollment, members give up their right to a jury or trial before a judge for the resolution of such disputes.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-877-609-8711** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by 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 an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-466-2219**) and a TTY line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet website <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?

With the HSP plan, Health Net members can go directly to any PureCare HSP participating provider, without a referral.

With the HMO plan, Health Net members have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Customer Contact Center at **1-877-609-8711**.

What are Health Net's premium ratios?

Health Net's 2013 ratio of health services paid to premium costs for Individual & Family HMO plans was 97.4%.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals, participating providers and other health care providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or

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

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

If Health Net's contract with a physician group, participating provider or other provider is terminated, Health Net will transfer any affected members to another contracting physician group or participating provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a physician group, participating provider or acute care hospital to which members are assigned for services, Health Net will provide a written notice to affected members. For all other hospitals that terminate 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.

In addition, the member 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:

- An acute condition;
- A serious chronic condition not to exceed

twelve months from the contract termination date;

- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A terminal illness (for the duration of the terminal illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of this 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 reasonably possible.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact Health Net's Customer Contact Center at the number on the back of your Health Net ID card.

What are severe mental illness and serious emotional disturbances of a child?

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 of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date), autism, anorexia nervosa, and bulimia nervosa.

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 abuse 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: (a) 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 (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Plan Contract and Evidence of Coverage and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at 1-877-609-8711 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

For its HMO plans, Health Net uses financial incentives and various risk-sharing arrangements when paying providers. For its HSP plans, 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.

When and how does Health Net pay my medical bills?

We will coordinate the payment for covered services when you receive care from your participating provider or PCP, or for HMO

plans, when you are referred by your PCP to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Health Net member ID card.

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

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

In serious emergency situations: Call “911” or go to the nearest hospital.

If your situation is not so severe: HMO plan members should call their primary care physician or physician group (medical) or the administrator (mental illness or detoxification). HSP plan members should call a participating provider (medical) or the administrator (mental disorders and chemical dependency).

If you are unable to call and you need medical care right away, go to the nearest medical center or hospital.

An emergency means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor’s parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment, and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or

(c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capacity of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.

All air and ground ambulance and ambulance transport services provided as a result of a 911 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).

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

For HSP plans, follow-up care (including severe mental illness and serious emotional disturbances of a child) after the

emergency or urgency has passed and your condition is stable, must be authorized by Health Net (medical) or the administrator (mental disorders and chemical dependency) or it will not be covered.

Am I liable for payment of certain services?

We are 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 *Plan Contract and EOC*; and (b) services not covered by the Individual & Family Plan. The Individual & Family Plans do not cover: prepayment fees, copayments, deductibles, services, and supplies not covered by the Individual & Family Plans, or non-emergency care rendered by a nonparticipating provider.

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

Some nonparticipating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment and the emergency room or urgent care center report to us for reimbursement within one year of the date the service was rendered. For the HMO plans, coverage for services rendered by nonparticipating providers is limited to emergency care and, when you are outside a 30-mile radius of your physician group, urgent care. For HSP plans, coverage for services rendered by nonparticipating or out-of-network provider is limited to emergency and urgently needed care.

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

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

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

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

Privacy practices

For a description of how protected health information about you may be used and disclosed and how you can get access to this information, please see the “Notice of Privacy Practices” in the plan’s plan contract.

How does Health Net deal with new technologies?

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

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

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient’s

medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is experimental or investigational, you may request an Independent Medical Review (IMR) of Health Net’s decision from the Department of Managed Health Care. Please refer to the “Independent Medical Review of Grievances Involving a Disputed Health Care Service” in the *Plan Contract and Evidence of Coverage* for additional details.

What are Health Net’s utilization management processes?

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

Preauthorization

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

Concurrent review

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

Discharge planning

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

Retrospective review

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been

provided. It is usually performed on cases where preauthorization was required but not obtained.

Care or case management

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

Additional product information

Mental disorders and chemical dependency services

The mental disorders and chemical dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the administrator) which contracts with Health Net to administer these benefits. When you need to see a participating mental health professional, contact the administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net ID card. The administrator will help you identify a participating mental health professional, a participating independent physician, or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the administrator is encouraged.

Please refer to the Health Net Individual & Family Plan *Plan Contract and Evidence of Coverage* for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the administrator.

Prescription drug program

Health Net is contracted with many major pharmacies, including supermarket-based pharmacies and privately owned pharmacies in California. Please visit our website at **www.healthnet.com** to find a conveniently located participating pharmacy, or call Health Net's Customer Contact Center at **1-877-609-8711**.

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

Maintenance prescriptions by mail order drug program

- For HMO plans, if your prescription is for a maintenance drug, you are required to fill your prescription through our convenient mail order program. You are required to obtain maintenance drugs through the mail order program after you have filled your prescription of at least a 30-day supply of the maintenance drug up to two (2) times from a retail pharmacy.
- For HSP plans, if your prescription is for a maintenance drug, you have the option of filling it through our convenient mail order program.

Maintenance drugs are prescription drugs taken continuously to manage chronic or long-term conditions where members respond positively to drug treatment. The mail order administrator may only dispense up to a 90-consecutive-calendar-day supply of a covered maintenance drug and each refill allowed by that order. Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit. You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at **1-877-609-8711**.

Note

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

The Health Net “Essential RX Drug List”: Tier I drugs (primarily generic) and Tier II drugs (primarily brand)

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

The “Essential RX Drug List” is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. This committee’s members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the “Essential 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 website at **www.healthnet.com**, or call Health Net’s Customer Contact Center at **1-877-609-8711**.

Tier III drugs

Tier III drugs are prescription drugs that are listed as Tier III or not listed on the “Essential RX Drug List” and are not excluded from coverage.

Specialty drugs

Specialty drugs are specific prescription drugs used to treat complex or chronic conditions and usually require close monitoring. These drugs may have limited pharmacy availability or distribution and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously). Specialty drugs are identified in the “Essential RX Drug List” with “SP”. Refer to Health Net’s “Essential RX Drug List” on our website at healthnet.com for the Specialty drugs listing.

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

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

What is “prior authorization”?

Some Tier I, Tier II and Tier III prescription medications require prior authorization.

This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Upon receiving your physician’s request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com, or contact the Health Net Customer Contact Center at the phone number on the back cover.

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. See “What if I have a disagreement with Health Net?” earlier in this guide.

Prescription drug program exclusions and limitations

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

- Allergy serum is covered as a medical benefit.
- Brand-name drugs that have generic equivalents are not covered without prior authorization from Health Net.

- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers, and diabetic supplies. No other devices are covered even if prescribed by a participating physician.
- Drugs prescribed for the treatment of obesity are not covered, except when medically necessary for the treatment of morbid obesity.
- Drugs prescribed to shorten the duration of the common cold.
- Experimental drugs (those that are labeled “Caution – Limited by Federal Law to investigational use only”). If you are denied coverage of a drug because the drug is investigational or experimental, you will have a right to an Independent Medical Review. See “What if I have a disagreement with Health Net” section of this brochure for additional information.
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices.
- Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are covered only when medically necessary or when the medication is only available in that form.
- For HMO plans only, maintenance drugs must be obtained through the mail order program in order to be covered.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.
- Some drugs are subject to specific quantity limitations per copayment based on recommendations for use by the FDA or Health Net’s usage guidelines. Medications taken on an “as-needed” basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net.
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs, 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 may be covered if medically necessary. 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 except in emergency or urgent care situations.
- Prescription drugs prescribed by a physician

who is not a member or participating physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated.

- Replacement of lost, stolen or damaged medications.
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net.
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover medically necessary drugs for medical conditions directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Drugs (including injectable medications), when medically necessary for treating sexual dysfunction, are limited to a maximum of 8 doses in any 30-day period.

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

Acupuncture care program

Acupuncture services are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*.

ASH Plans will arrange covered acupuncture services for you. You may access any contracted acupuncturist without a referral from a participating provider, physician or your PCP.

You may receive covered acupuncture services from any contracted acupuncturist, and you are not required to pre-designate a contracted acupuncturist prior to your visit from whom you will receive covered acupuncture services. You must receive covered acupuncture services from a contracted acupuncturist, except that:

- You may receive emergency acupuncture services from any acupuncturist, including a non-contracted acupuncturist; and
- If covered acupuncture services are not available and accessible to you in the county in which you live, you may obtain covered acupuncture services from a non-contracted acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH plans.

All covered acupuncture services require pre-approval by ASH plans except:

- A new patient examination by a contracted acupuncturist and the provision or commencement, in the new patient examination, of medically necessary services that are covered acupuncture services, to the extent consistent with professionally recognized standards of practice; and
- Emergency acupuncture services.

Acupuncture care program exclusions and limitations

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

- Auxiliary aids and services are not covered;
- Services provided by an acupuncturist practicing outside California are not covered, except with regard to emergency acupuncture services;
- Diagnostic radiology, including MRIs or thermography are not covered;
- X-rays, laboratory tests and X-ray second opinions;
- Hypnotherapy, behavioral training, sleep therapy, and weight programs are not covered;
- Educational programs, non-medical self-care, self-help training and related diagnostic testing are not covered;
- Experimental or investigational acupuncture services are not covered;
- Charges for hospital confinement and related services are not covered;
- Charges for anesthesia are not covered;
- Services or treatment rendered by acupuncturists who do not contract with ASH plans are not covered, except with regard to emergency acupuncture services;
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered.

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

Pediatric vision care program (birth through age 18)

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

Professional services	Copayment
Routine eye examination with dilation	\$0 ¹
Examination for contact lenses	
Standard contact lens fit and follow-up	up to \$55
Premium contact lens fit and follow-up	10% off retail
<p>Limitation: ¹In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every calendar year.</p> <p>Note: Examination for contact lenses is in addition to the member's vision examination. There is no additional copayment for a contact lens follow-up visit after the initial fitting exam.</p> <p>Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one time use benefits. No remaining balance.</p> <p>Standard contact lenses include soft, spherical and daily wear contact lenses.</p> <p>Premium contact lenses include toric, bifocal, multifocal, cosmetic color, post-surgical, and gas permeable contact lenses.</p>	

Materials (includes frames and lenses)	Copayment
Provider selected frames (one every 12 months)	\$0
Standard plastic eyeglass lenses (one pair every 12 months) <ul style="list-style-type: none"> • Single vision, bifocal, trifocal, lenticular 	\$0
<ul style="list-style-type: none"> • Glass or plastic 	
Optional lenses and treatments including: <ul style="list-style-type: none"> • UV treatment • Tint (fashion & gradient & glass-grey) • Standard plastic scratch coating • Standard polycarbonate • Photocromatic / transitions plastic • Standard anti-reflective coating • Polarized • Standard progressive lens • Hi-index lenses • Blended segment lenses • Intermediate vision lenses • Select or ultra progressive lenses 	\$0
Materials (includes frames and lenses)	Copayment
Premium progressive lenses	\$0
Provider selected contact lenses (In lieu of eyeglass lenses) <ul style="list-style-type: none"> • Extended wear disposables: Up to 6-month supply of monthly or 2-week supply of 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: One pair from selection of provider designated contact lenses • Medically necessary² 	\$0
² Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions: <ul style="list-style-type: none"> • High Ametropia exceeding -10D or +10D in meridian powers • Anisometropia of 3D in meridian powers • Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses • Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses 	

Medically necessary contact lenses:

Coverage of medically necessary contact lenses is subject to medical necessity, prior authorization from Health Net and all applicable exclusions and limitations.

Pediatric vision care program exclusions and limitations

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

- 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.
 - Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this plan.
 - A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net participating vision providers offer discounts of up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.
- This is only a summary.** For a comprehensive listing see the Health Net Individual & Family Plan *Plan Contract and Evidence of Coverage*.

Pediatric dental services (birth through age 18)

All of the following services must be provided by your selected Health Net participating primary dental provider in order to be covered.

If you have purchased a supplemental pediatric dental benefit plan on the Exchange, 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 your *Evidence of Coverage* document.

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

Code	Service	Copayment
Diagnostic		
D0120	Periodic oral evaluation – established patient	\$0
D0140	Limited oral evaluation – problem focused	\$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D0150	Comprehensive oral evaluation – new or established patient	\$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$0
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	\$0
D0180	Comprehensive periodontal evaluation – new or established patient	\$0
D0210	X-rays Intraoral – complete series (including bitewings)	\$0
D0220	X-rays Intraoral – periapical first film	\$0
D0230	X-rays Intraoral – periapical each additional film	\$0
D0240	X-rays Intraoral – occlusal film	\$0
D0250	Extraoral – first film	\$0
D0260	Extraoral – each additional film	\$0
D0270	X-rays Bitewing – single film	\$0
D0272	X-rays Bitewings – two films	\$0
D0273	X-rays Bitewings – three films	\$0
D0274	X-rays Bitewings – four films	\$0
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	Panoramic film	\$0
D0415	Collect Microorganisms cult and sensitivity	\$0
D0425	Caries Susceptibility tests	\$0
D0431	Adjunct pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$0
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
D0601	Caries risk assessment and documentation, with a finding of low risk	\$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	\$0
D0603	Caries risk assessment and documentation, with a finding of high risk	\$0
D0999	Office visit fee – per visit	\$0
Preventive		
D1120	Prophylaxis – child	\$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	\$0
D1208	Topical application of fluoride	\$0

(continued)

Code	Service	Copayment
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$0
D1352	Prevent resin rest in mod to high risk patients	\$0
D1510	Space maintainer – fixed – unilateral	\$0
D1515	Space maintainer – fixed – bilateral	\$0
D1520	Space maintainer – removable – unilateral	\$0
D1525	Space maintainer – removable – bilateral	\$0
D1550	Re-cementation of space maintainer	\$0
D1555	Removal of fixed space maintainer	\$0
Restorative		
D2140	Amalgam – one surface, primary or permanent	\$25
D2150	Amalgam – two surfaces, primary or permanent	\$25
D2160	Amalgam – three surfaces, primary or permanent	\$25
D2161	Amalgam – four or more surfaces, primary or permanent	\$25
D2330	Resin-based composite – one surface, anterior	\$25
D2331	Resin-based composite – two surfaces, anterior	\$25
D2332	Resin-based composite – three surfaces, anterior	\$25
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$25
D2390	Resin-based composite crown, anterior	\$25
D2391	Resin-based composite – one surface, posterior (permanent tooth)	\$25
D2392	Resin-based composite – two surfaces, posterior (permanent tooth)	\$25
D2393	Resin-based composite – three surfaces, posterior (permanent tooth)	\$25
D2394	Resin-based composite – four or more surfaces, posterior (permanent tooth)	\$25
D2510	Inlay – metallic – one surface	\$235
D2520	Inlay – metallic – two surfaces	\$245
D2530	Inlay – metallic – three or more surfaces	\$260
D2542	Onlay – metallic – two surfaces	\$275
D2543	Onlay – metallic – three surfaces	\$285
D2544	Onlay – metallic – four or more surfaces	\$300
D2610	Inlay – porcelain/ceramic – 1 surface	\$275
D2620	Inlay – porcelain/ceramic – 2 surfaces	\$285
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	\$300
D2642	Onlay – porcelain/ceramic – 2 surfaces	\$285
D2643	Onlay – porcelain/ceramic – 3 surfaces	\$300
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	\$300
D2650	Inlay – resin based composite – 1 surface	\$215
D2651	Inlay – resin based composite – 2 surfaces	\$235
D2652	Inlay – resin based composite – 3 or more surfaces	\$245

Code	Service	Copayment
D2662	Onlay – resin based composite – 2 surfaces	\$225
D2663	Onlay – resin based composite – 3 surfaces	\$255
D2664	Onlay – resin based composite – 4 or more surfaces	\$275
Crowns – Single Restorations Only		
D2710	Crown – Resin-based composite (indirect)	\$140
D2712	Crown – ¾ resin-based composite (indirect)	\$140
D2720	Crown – Resin with high noble metal	\$300
D2721	Crown – Resin with predominantly base metal	\$300
D2722	Crown – Resin with noble metal	\$300
D2740	Crown – porcelain/ceramic substrate	\$300
D2750	Crown – porcelain fused to high noble metal	\$300
D2751	Crown – porcelain fused to predominantly base metal	\$300
D2752	Crown – porcelain fused to noble metal	\$300
D2780	Crown – 3/4 cast high noble metal	\$300
D2781	Crown – 3/4 cast predominantly base metal	\$300
D2782	Crown – 3/4 cast noble metal	\$300
D2783	Crown – 3/4 porcelain/ceramic	\$300
D2790	Crown – full cast high noble metal	\$300
D2791	Crown – full cast predominantly base metal	\$300
D2792	Crown – full cast noble metal	\$300
D2794	Crown – titanium	\$300
D2910	Recement inlay, onlay, or partial coverage restoration	\$35
D2915	Recement cast or prefabricated post and core	\$35
D2920	Recement crown	\$35
D2921	Re-attachment of tooth fragment, incisal edge or cusp	\$25
D2930	Prefabricated stainless steel crown – primary tooth	\$85
D2931	Prefabricated stainless steel crown – permanent tooth	\$100
D2932	Prefabricated Resin Crown	\$100
D2933	Prefabricated Stainless steel crown resin window	\$120
D2934	Prefabricated Esthetic coated Stainless steel	\$115
D2940	Sedative filling	\$25
D2941	Interim therapeutic restoration – primary dentition	\$25
D2950	Core buildup, including any pins	\$80
D2951	Pin retention – per tooth, in addition to restoration	\$15
D2952	Cast post and core in addition to crown, indirectly fabricated	\$110
D2953	Each additional indirectly fabricated cast post – same tooth	\$65
D2954	Prefabricated post and core in addition to crown	\$94
D2955	Post removal	\$30
D2957	Each additional prefabricated post – same tooth	\$64
D2960	Labial veneer (resin based) – chairside	\$270
D2962	Labial veneer (porcelain laminate)	\$300
D2970	Temporary crown	\$0

(continued)

Code	Service	Copayment
D2971	Additional procedures to construct new crown under existing partial dental framework	\$65
D2980	Crown repair, by report	\$70
D2981	Inlay repair necessitated by restorative material failure	\$70
D2982	Onlay repair necessitated by restorative material failure	\$70
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	\$15
D3120	Pulp cap – indirect (excluding final restoration)	\$15
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$75
D3221	Pupal debri primary and permanent teeth	\$55
D3222	Partial Pulpotomy for apexogenesis	\$55
D3230	Pulpal therapy – anterior, primary tooth	\$60
D3240	Pulpal therapy – posterior, primary tooth	\$70
D3310	Anterior (excluding final restoration)	\$195
D3320	Bicuspid (excluding final restoration)	\$275
D3330	Molar (excluding final restoration)	\$300
D3331	Treatment of root canal obstruction; non-surgical access	\$105
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$105
D3333	Internal root repair of perforation defects	\$105
D3346	Retreatment of previous root canal therapy – anterior	\$275
D3347	Retreatment of previous root canal therapy – bicuspid	\$300
D3348	Retreatment of previous root canal therapy – molar	\$300
D3351	Apexification/recalcification – initial visit	\$110
D3352	Apexification/recalcification – interim	\$55
D3353	Apexification/recalcification – final visit	\$175
D3355	Pulpal regeneration – initial visit	\$110
D3356	Pulpal regeneration -interim medicament replacement	\$55
D3357	Pulpal regeneration – completion of treatment	\$175
D3410	Apicoectomy/periradicular surgery – anterior	\$265
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$295
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$300
D3426	Apicoectomy/periradicular surgery (each additional root)	\$90
D3427	Periradicular surgery without apicoectomy	\$90
D3430	Retrograde filling – per root	\$65
D3450	Root amputation – per root	\$135
D3910	Surgical procedure for isolation of tooth with rubber dam	\$30
D3920	Hemisection (including any root removal), not including root canal therapy	\$115
D3950	Canal preparation and fitting of preformed dowel or post	\$30
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces – per quadrant	\$150

Code	Service	Copayment
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces – per quadrant	\$75
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces – per quadrant	\$225
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces – per quadrant	\$155
D4245	Apically positioned flap	\$240
D4249	Clinical crown lengthening – hard tissue	\$175
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces – per quadrant	\$300
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces – per quadrant	\$275
D4263	Bone replacement graft – first site in quadrant	\$225
D4264	Bone replacement graft – each additional site in quadrant	\$135
D4270	Pedicle soft tissue graft procedure	\$285
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$95
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	\$285
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant	\$65
D4342	Periodontal scaling and root planing – one to three teeth – per quadrant	\$35
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$65
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$35
D4910	Periodontal maintenance	\$45
D4920	Unscheduled dressing change	\$0
Prosthodontics		
D5110	Complete denture – maxillary	\$300
D5120	Complete denture – mandibular	\$300
D5130	Immediate denture – maxillary	\$300
D5140	Immediate denture – mandibular	\$300
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$300
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$300
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$300
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$300
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	\$300
D5226	Madibular partial denture – flexible base (including any clasps, rests and teeth)	\$300
D5281	Remv Uni Part Denture – 1 PC cast metal	\$290
D5410	Adjust complete denture – maxillary	\$25

(continued)

Code	Service	Copayment
D5411	Adjust complete denture – mandibular	\$25
D5421	Adjust partial denture – maxillary	\$25
D5422	Adjust partial denture – mandibular	\$25
D5510	Repair broken complete denture base	\$55
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$45
D5610	Repair resin denture base	\$55
D5620	Repair cast framework	\$55
D5630	Repair or replace broken clasp	\$60
D5640	Replace broken teeth – per tooth	\$48
D5650	Add tooth to existing partial denture	\$55
D5660	Add clasp to existing partial denture	\$65
D5670	Replace all teeth & acrylic framework maxillary	\$175
D5671	Replace all teeth & acrylic framework mandibular	\$175
D5710	Rebase complete maxillary denture	\$180
D5711	Rebase complete mandibular denture	\$180
D5720	Rebase maxillary partial denture	\$170
D5721	Rebase mandibular partial denture	\$170
D5730	Reline complete maxillary denture (chairside)	\$95
D5731	Reline complete mandibular denture (chairside)	\$95
D5740	Reline maxillary partial denture (chairside)	\$95
D5741	Reline mandibular partial denture (chairside)	\$95
D5750	Reline complete maxillary denture (laboratory)	\$135
D5751	Reline complete mandibular denture (laboratory)	\$135
D5760	Reline maxillary partial denture (laboratory)	\$135
D5761	Reline mandibular partial denture (laboratory)	\$135
D5820	Interim partial denture (maxillary)	\$165
D5821	Interim partial denture (mandibular)	\$165
D5850	Tissue conditioning, maxillary	\$40
D5851	Tissue conditioning, mandibular	\$40
D5863	Overdenture – complete maxillary	\$300
D5864	Overdenture – complete mandibular	\$300
D5865	Overdenture – partial maxillary	\$300
D5866	Overdenture – partial mandibular	\$300
D5999	Denture duplication	\$225
Prosthodontics (Fixed)		
D6205	Pontic – indirect resin-based composite	\$175
D6210	Pontic – cast high noble metal	\$300
D6211	Pontic – cast predominantly base metal	\$300
D6212	Pontic – cast noble metal	\$300
D6214	Pontic – titanium	\$300
D6240	Pontic – porcelain fused to high noble metal	\$300
D6241	Pontic – porcelain fused to predominantly base metal	\$300

Code	Service	Copayment
D6242	Pontic – porcelain fused to noble metal	\$300
D6245	Pontic – porcelain/ceramic	\$300
D6250	Crown – porcelain fused to high noble metal	\$300
D6251	Crown – porcelain fused to predominantly base metal	\$300
D6252	Crown – porcelain fused to noble metal	\$300
D6600	Inlay – porcelain/ceramic, 2 surfaces	\$285
D6601	Inlay – porcelain/ceramic, 3 or more surfaces	\$300
D6602	Inlay – cast high noble metal, 2 surfaces	\$245
D6603	Inlay – cast high noble metal, 3 or more surfaces	\$260
D6604	Inlay – cast predominantly base metal, 2 surfaces	\$235
D6605	Inlay – cast predominantly base metal, 3 ore more surfaces	\$250
D6606	Inlay – cast noble metal, 2 surfaces	\$235
D6607	Inlay – cast noble metal, 3 or more surfaces	\$255
D6608	Onlay – porcelain/ceramic, 2 surfaces	\$250
D6609	Onlay – porcelain/ceramic, 3 or more surfaces	\$255
D6610	Onlay – cast high noble metal 2 surfaces	\$300
D6611	Onlay – cast high noble metal 3 or more surfaces	\$300
D6612	Onlay – cast predominantly base metal 2 surfaces	\$300
D6613	Onlay – cast predominantly base metal 3 or more surfaces	\$300
D6614	Onlay – cast noble metal 2 surfaces	\$300
D6615	Onlay – cast noble metal 3 or more surfaces	\$300
D6624	Inlay titanium	\$245
D6634	Onlay titanium	\$255
D6710	Crown – indirect resin-based composite	\$175
D6720	Crown – resin with high noble metal	\$300
D6721	Crown – resin predominantly base metal – denture	\$300
D6722	Crown – resin with noble metal	\$300
D6740	Crown – porcelain/ceramic	\$300
D6750	Crown – porcelain fused to high noble metal	\$300
D6751	Crown – porcelain fused to predominantly base metal	\$300
D6752	Crown – porcelain fused to noble metal	\$300
D6780	Crown – 3/4 cast high noble metal	\$300
D6781	Crown – 3/4 cast predominantly base metal	\$300
D6782	Crown – 3/4 cast noble metal	\$300
D6783	Crown ³ / ₄ porcelain/ceramic-denture	\$300
D6790	Crown – full cast high noble metal	\$300
D6791	Crown – full cast predominantly base metal	\$300
D6792	Crown – full cast noble metal	\$300
D6794	Crown – titanium	\$300
D6930	Recement fixed partial denture	\$48
D6940	Stress breaker	\$120
D6980	Fixed partial denture repair, by report	\$60

(continued)

Code	Service	Copayment
Oral surgery		
D7111	Extraction, coronal remnants – deciduous tooth	\$15
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$45
D7220	Removal of impacted tooth – soft tissue	\$50
D7230	Removal of impacted tooth – partially bony	\$50
D7240	Removal of impacted tooth – completely bony	\$160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$95
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$90
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$65
D7280	Surgical access exposure of an unerupted tooth	\$125
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$135
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$85
D7286	Biopsy of oral tissue – soft (all others)	\$55
D7288	Brush biopsy – transepithelial sample collection	\$0
D7310	Alveoplasty in conjunction with extractions – per quadrant	\$50
D7311	Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$40
D7320	Alveoplasty not in conjunction with extractions – per quadrant	\$75
D7321	Alveoplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	\$65
D7410	Excision of benign lesion up 1/25 cm	\$175
D7411	Excision of benign lesion greater than 1.25 cm	\$300
D7412	Excision of benign lesion, complicated	\$300
D7450	Removal of benign odontogenic cyst up to 1.25 cm	\$200
D7451	Removal of benign odontogenic cyst greater than 1.25 cm	\$285
D7460	Removal of benign nonodontogenic cyst up to 1.25 cm	\$200
D7461	Removal of benign nonodontogenic cyst greater than 1.25 cm	\$285
D7471	Removal of lateral exostosis	\$165
D7472	Removal of torus palatines	\$300
D7473	Removal of torus mandibularis	\$265
D7485	Surgical reduction of osseous tuberosity	\$75
D7510	Incision and drainage of abscess – intraoral soft tissue	\$20
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$35
D7520	Incision and drainage of abscess – extraoral soft tissue	\$275
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated	\$300
D7910	Suture of recent small wounds up to 5 cm	\$35
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$25
D7963	Frenuloplasty	\$55

Code	Service	Copayment
D7970	Excision of hyperplastic tissue – per arch	\$65
D7971	Excision of pericoronal gingiva	\$55
D7972	Surgical reduction of fibrous tuberosity	\$145
D7999	Unspecified oral surgery procedure, by report	\$10
Orthodontics	Medically necessary banded case	\$1,000
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8660	Pre-orthodontic treatment visit	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive general services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$10
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$5
D9211	Regional block anesthesia	\$5
D9212	Trigeminal division block anesthesia	\$10
D9215	Local anesthesia	\$5
D9220	Deep sedation/general anesthesia – first 30 minutes	\$95
D9221	Deep sedation/general anesthesia – each additional 15 minutes	\$80
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$10
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	\$155
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	\$60
D9248	Non-intravenous conscious sedation	\$20
D9310	Consultation – diagnostic service provided by dentist or physician (other than practitioner providing treatment)	\$20
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$20
D9440	Office visit – after regularly scheduled hours	\$35
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9930	Treatment of complications – post surgery	\$0
D9940	Occlusal guard by report	\$175
D9951	Occlusal adjustment – limited	\$55
D9952	Occlusal adjustment – complete	\$165
D9972	External bleaching – per arch	\$125
D9999	Broken appointment	\$10

Dental codes from “Current Dental Terminology© American Dental Association.”

Pediatric dental care program exclusions and limitations

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

- Prophylaxis services (cleanings) are limited to two every 12 months.
- Fluoride treatment is covered twice in any 12 month period.
- Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period.

- Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
 - Panoramic film x-rays are limited to once every 24 consecutive months
 - Dental sealant treatments are limited to permanent first and second molars only.
 - Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.
 - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.
 - Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling.
 - Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
 - Tissue conditioning is limited to two per denture.
 - A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person under the age of 19. For children under the age of 19, it is considered optional dental treatment. If performed on a member under the age of 19, the applicant must pay the difference in cost between the fixed bridge and a space maintainer. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.
- The following services, if in the opinion of the attending dentist or Health Net are not dentally necessary, will not be covered:
 - Temporomandibular joint treatment (aka “TMJ”).
 - Elective dentistry and cosmetic dentistry.
 - Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
 - Treatment of malignancies, cysts, neoplasms or congenital malformations.
 - Prescription medications.
 - Hospital charges of any kind.
 - Loss or theft of full or partial dentures.
 - Any procedure of implantation.
 - Any experimental procedure.
 - General anesthesia or intravenous/ conscious sedation, except as specified in the medical benefits section.
 - Services that cannot be performed because of the physical or behavioral limitations of the patient.
 - Fees incurred for broken or missed appointments (without 24 hours’ notice) are the member’s responsibility. However, the copayment for missed appointments may not apply if: (1) the member canceled

at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.

- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Services that were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her plan provider is a pedodontist/pediatric dentist.
- Pediatric dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonable should have known that an emergency care situation did not exist.

Orthodontic benefits

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

Referrals to specialists for orthodontic care

Each member's primary dentist is responsible for the direction and coordination of the member's complete dental care for denefits. 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*.

Individual & Family Plan exclusions and limitations

Exclusions and limitations common to all Individual & Family Plan Exchange plans

No payment will be made under the Health Net Individual & Family Plans for expenses incurred for, or which are follow-up care to, any of the items below. The following is a selective listing only. For a comprehensive listing, see the Health Net Individual & Family Plan *Plan Contract and Evidence of Coverage*.

- Services and supplies which Health Net determines are not medically necessary, except as set out under “Does Health Net cover the cost of participation in clinical trials?” and “What if I have a disagreement with Health Net” earlier in this guide.
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.
- Custodial Care. Custodial Care is not rehabilitative care and is provided to assist a patient in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net determines to be experimental or investigational, except as set out under “Does Health Net cover the cost of participation in clinical trials?” and “What if I have a disagreement with Health Net” earlier in this guide.
- Services or supplies provided before the effective date of coverage and services or supplies provided after coverage through this plan has ended are not covered.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.²

²When a medically necessary mastectomy (including lumpectomy) has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.

- Treatment and services for Temporomandibular Joint Disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework, and appliances.
- This plan only covers services or supplies provided by a legally operated hospital, Medicare-approved Skilled Nursing Facility, or other properly licensed facility specified as covered in the plan's *Plan Contract and EOC*. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.
- Dental care for individuals age 19 and older. However, this plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise medically necessary. See the "Dental care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses except as set out under the pediatric dental care program earlier in this guide.
- Services to reverse voluntary surgically induced infertility.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the plan does cover medically necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery.)
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's *Plan Contract and EOC*.
- Immunizations and injections for foreign travel/occupational purposes.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. When compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan covers Durable Medical Equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (c) surgical dressings other than primary dressings that are applied by your participating provider, physician group or a hospital to lesions of the skin or surgical incisions; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders

of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over-the-counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; and (g) orthotics and corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications).

- Personal comfort items.
- Disposable supplies for home use, except certain disposable ostomy or urological supplies. See the *Plan Contract and EOC* for your benefit plan for additional information.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Treatment by immediate family members.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, a participating provider (medical), the physician group (medical) or the administrator (mental disorders or chemical dependency) according to Health Net's procedures.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drug, medical equipment or supply that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception approved by the

FDA). If a drug that was previously available by prescription becomes available in an over-the-counter (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 prior authorization is obtained from Health Net. However, if a higher dosage nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.

- Routine foot care, unless prescribed for the treatment of diabetes or peripheral vascular disease.
- Services to diagnose, evaluate or treat infertility are not covered.
- Except for services related to behavioral health treatment for pervasive developmental disorder or autism, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the State of California.
- Treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be experimental or investigational in nature. For information regarding requesting an Independent Medical Review of a plan denial of coverage on the basis that it is considered experimental or investigational, see "What if I have a disagreement with Health Net" earlier in this guide.
- Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net

Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. Health Net has a specific network of bariatric facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your member physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.

- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.
- Coverage for rehabilitation and habilitation therapy is limited to medically necessary services provided by a plan contracted physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the plan or the member's medical group. The services must be based on a treatment plan authorized as required by the plan or the member's medical group.
- Electro-convulsive therapy is not covered except as authorized by the administrator.
- The following types of treatment are only covered when provided in connection with covered treatment for a mental disorder or chemical dependency: (a) treatment for co-dependency; (b) treatment for psychological stress; and (c) treatment of marital or family dysfunction. Treatment of Delirium,

Dementia, Amnesic Disorders (as defined in the DSM-IV) and Mental Retardation are covered for medically necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment. In addition, Health Net will cover only those mental disorder or chemical dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law.

- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy, and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage, see "What if I have a disagreement with Health Net?" earlier in this guide.
- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain, and as otherwise preauthorized by the administrator.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated, computer-based reports, unless the scoring is performed by a provider qualified to perform it.
- Residential treatment that is not medically necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for

wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

- Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
- Treatment or consultations provided by telephone are not covered.
- Medical, mental health care or chemical dependency services as a condition of parole or probation, and court-ordered testing are limited to medically necessary covered services.
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or physician-directed and is obtained for the purposes of checking a member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.

Additional exclusions and limitations for all HSP plans

- This plan does not cover massage therapy, except when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Health Net.
- 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.

Additional exclusions and limitations for all HMO plans

- This plan does not cover massage therapy, except when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Health Net or your physician group services and supplies rendered by a nonparticipating physician without prior authorization from Health Net or the physician group are not covered.
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by your physician group (medical), the administrator (mental disorders or chemical dependency) or when you require emergency or urgently needed care.



No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or please call:

Individual & Family Plans: 1-888-926-4988
Small Business: 1-888-926-5133
TDD/TYY: 1-888-926-5180

For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al:

Planes Individuales y Familiares: 1-888-926-4988
Pequeñas Empresas: 1-888-926-5133
TDD/TYY: 1-888-926-5180

Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或請撥：

Individual & Family Plans : 1-888-926-4988
小型企業 : 1-888-926-5133
聽 / 語障專線 : 1-888-926-5180

如需其他協助：如果您投保的是由 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是由 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi:

Chương trình bảo hiểm dành cho cá nhân và gia đình: 1-888-926-4988
Chương trình bảo hiểm dành cho tiểu thương nghiệp: 1-888-926-5133
Số TDD/TYY: 1-888-926-5180

Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 다음 안내번호로 문의하십시오.

개인 및 가족 플랜: 1-888-926-4988
스몰 비즈니스: 1-888-926-5133
TDD/TTY: 1-888-926-5180

더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o mangyaring tumawag sa:

Individual & Family Plans: 1-888-926-4988

Small Business: 1-888-926-5133

TDD/TTY: 1-888-926-5180

Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվանար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ խնդրում ենք զանգահարել

Անհատական և Ընտանեկան Ծրագրեր՝ 1-888-926-4988

Փոքր Ձեռնարկություններ՝ 1-888-926-5133

Խոսկերի համար սարք (TDD/TTY)՝ 1-888-926-5180

Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте.

Планы индивидуального и семейного страхования: 1-888-926-4988

Малый бизнес: 1-888-926-5133

Линия TDD/TTY: 1-888-926-5180

Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または以下の番号までご連絡ください。

個人および家族プラン：1-888-926-4988

中小企業：1-888-926-5133

TDD/TTY専用番号：1-888-926-5180

さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس گرفته و یا به شماره های زیر تلفن کنید:

طرح افراد و خانواده ها: 1-888-926-4988

کسب و کار کوچک: 1-888-926-5133

TDD/TTY: 1-888-926-5180

برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسایی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਬਾਰੀਆਂ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇਥੇ ਫੋਨ ਕਰੋ:

ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾਵਾਂ: 1-888-926-4988

ਛੋਟਾ ਕਾਰੋਬਾਰ: 1-888-926-5133

TDD/TTY: 1-888-926-5180

ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

ਯੋਜਨਾ ਲਈ ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

ਯੋਜਨਾ ਲਈ ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

ਯੋਜਨਾ ਲਈ ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

ਯੋਜਨਾ ਲਈ ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ। ਸੇਵਾਗਰਹਿਣੀਆਂ/ਸੇਵਾਗਰਹਿਣੀਆਂ ਨੂੰ ਮੁਫਤ ਸੇਵਾਵਾਂ ਮਿਲ ਸਕਦੀਆਂ ਹਨ।

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis thov hu rau:

Kev Npaj Pab Tus Kheej thiab Tsev Neeg (Individual and Family Plan; IFP): 1-888-926-4988

Cov Lagluam Me: 1-888-926-5133

Tus Xovtooj TDD/TTY: 1-888-926-5180

Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bqah 'Alinígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóo naaltsoos bee 'éedahozinígíí t'áá ni nizaad bee hadadilyaago nich'í' yidóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nit'izi bee nééhozinígíí bine'déé' béésh bee hanéi biká'ígíí bee nich'í' hodíilnih, doodago t'áá shqódi kohji' hodíilnih:

Ła' Jizh dóo Hooghan Haz'áagi Naaltsoos Hadadít'éhígíí (IFP): 1-888-926-4988

T'áá 'altszíisigo Naalyéhi Báhooghan Daayéelyeedígíí: 1-888-926-5133

TDD/TTY: 1-888-926-5180

T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'áqáh naa'nil bibee haz'áanii Health Net Life Insurance Company bich'í' haidiilaagíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'ách'áqáh naa'nil bił haz'ánígíí bich'í' kohji' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóo HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohji' 1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nit'izi bine'déé' bikáá'.

Navajo

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على مساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو الاتصال بـ:

خطط الفرد والأسرة: 1-888-926-4988

Small Business (الأعمال الصغيرة): 1-888-926-5133

رقم الهاتف النصي/خط ضعاف السمع: 1-888-926-5180

للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

Health Net Individual & Family Plans

PO Box 1150

Rancho Cordova, CA 95741-1150

1-877-609-8711 (*English*)

1-877-891-9050 (*Cantonese*)

1-877-339-8596 (*Korean*)

1-877-891-9053 (*Mandarin*)

1-800-331-1777 (*Spanish*)

1-877-891-9051 (*Tagalog*)

1-877-339-8621 (*Vietnamese*)

Assistance for the Hearing and Speech Impaired

1-800-995-0852

www.healthnet.com

