EVIDENCE OF COVERAGE AND PLAN DOCUMENT

A complete explanation of your Plan

Full Network HMO Gold $40

Important benefit information - please read

1/2026 SG HMO

Dear Health Net Member:

Thank you for choosing Health Net to provide your health care benefits. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

This is your new Health Net *Evidence of Coverage*.

If your Group has requested that we make it available, you can access this document online through Health Net's secure website at www.healthnet.com. You can also elect to have a hard copy of this *Evidence of Coverage* mailed to you. Please call the telephone number on the back of your Member identification card to request a copy.

We look forward to serving you. Contact us at www.healthnet.com 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at one of the numbers below. Our Customer Contact Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

Thank you for choosing Health Net.

About This Booklet

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

This *Evidence of Coverage* constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

See the "Notice of Privacy Practices" under "Miscellaneous Provisions" for information regarding your right to request confidential communications.

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Health Net ID card, your Physician Group or your Primary Care Physician.

Use of Special Words

Special words used in this *Evidence of Coverage* to explain your Plan have their first letter capitalized and appear in the "Definitions" section.

The following words are used frequently:

- "**You**" or "**Your**" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- "**Employee**" has the same meaning as the word "You" above.
- "**We,**" "**Our**" or "**Us**" refers to Health Net.
- "**Subscriber**" means the primary Member, generally an employee of a Group.
- "**Physician Group**" or "**Participating Physician Group (PPG)**" means the medical group the individual Member selected as the source of all covered medical care.
- "**Primary Care Physician**" is the individual Physician each Member selected who will provide or authorize all covered medical care.
- "**Group**" is the business entity (usually an employer) that contracts with Health Net to provide this coverage to you.
- "***Evidence of Coverage***" **(*EOC*)** have similar meanings. You may think of these as meaning your Health Net benefits.

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INTRODUCTION TO HEALTH NET

The coverage described in this *Evidence of Coverage* 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 *Evidence of Coverage* do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, and are not subject to any pre-existing condition or exclusion period.

How to Obtain Care

When you enroll in this Plan, you must select a contracting Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. For contact information on your Physician Group, please call the Customer Contact Center.

In addition, CVS MinuteClinic licensed practitioners are available to provide you with treatment of common illnesses, vaccinations and other health services inside CVS/pharmacy stores. However, Specialist referrals following care from CVS MinuteClinic must be obtained through the contracting Physician Group. Members traveling in another state which has a CVS Pharmacy with a MinuteClinic can access MinuteClinic covered services under this Plan at that MinuteClinic under the terms of this *Evidence of Coverage*.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *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 the Customer Contact Center at 1-800-522-0088 to ensure that you can obtain the Health Care Services that you need.

Transition of Care for New Enrollees

You may request continued care from a provider, including a Hospital that does not contract with Health Net if, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the Member's Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;

- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

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

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see the "Definitions" section.

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments, Coinsurance, or Calendar Year Deductibles and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's effective date and you make the request as soon as reasonably possible. The nonparticipating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or request a copy of the Continuity of Care Request Form, or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Selecting a Primary Care Physician

Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your Family Members, subject to the requirements set out below under "Selecting a Contracting Physician Group."

For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician and a list of the participating Primary Care Physicians in the Health Net Service Area are available on the Health Net website at www.healthnet.com. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more. You can also call the Customer Contact Center at the number shown on your Health Net ID card to request provider information.

Selecting a Contracting Physician Group

Each person must select a Primary Care Physician at a contracting Physician Group close enough to their residence or place of work to allow reasonable access to medical care. Family Members may select different contracting Physician Groups.

A Subscriber who resides outside the Health Net Service Area may enroll based on the Subscriber's work address that is within the Health Net Service Area. Family Members who reside outside the Health Net Service Area may also enroll based on the Subscriber's work address that is within the Health Net Service Area. If you choose a Physician Group based on its proximity to the Subscriber's work address, you will need to travel to that Physician Group for any nonemergency or nonurgent care that you receive. Additionally, some Physician Groups may decline to accept assignment of a Member whose home or work address is not close enough to the Physician Group to allow reasonable access to care. Please call the Customer Contact Center at the number shown on your Health Net ID card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.healthnet.com.

Selecting a Participating Mental Health Professional

When you need to see a Participating Mental Health Professional, contact the Health Net Customer Contact Center at the phone number on your Health Net ID card. Health Net will help you identify a Participating Mental Health Professional, within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for Mental Health and Substance Use Disorders may require Prior Authorization by Health Net in order to be covered. Upon request, the criteria used to review the Prior Authorization request, and any education program materials used to develop these criteria, will be provided to you at no cost. This information is available online at our website at www.healthnet.com. You can also call the Health Net Customer Contact Center at the telephone number on your Health Net ID card to request the information.

Please refer to the "Mental Health and Substance Use Disorders" provision in the "Covered Services and Supplies" section for a complete description of Mental Health and Substance Use Disorder services and supplies, including those that require Prior Authorization by Health Net.

Specialists and Referral Care

Sometimes, you may need care that the Primary Care Physician cannot provide. At such times, you will be referred to a Specialist or other health care provider for that care. Refer to the "Selecting a Participating Mental Health Professional" section above for information about receiving care for Mental Health and Substance Use Disorders.

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

Standing Referral to Specialty Care for Medical and Surgical Services

A standing referral is a referral to a participating Specialist for more than one visit without your Primary Care Physician having to provide a specific referral for each visit. You may receive a standing referral to a Specialist if your continuing care and recommended treatment plan is determined Medically Necessary by your Primary Care Physician, in consultation with the Specialist, Health Net's Medical Director and you. The treatment plan may limit the number of visits to the Specialist, the period of time that the visits are authorized or require that the Specialist provide your Primary Care Physician with regular reports on the health care provided. Extended access to a participating Specialist is available to Members who have a life threatening, degenerative, or disabling condition (for example, Members with HIV/AIDS). To request a standing referral, ask your Primary Care Physician or Specialist.

If you see a Specialist before you get a referral, you may have to pay for the cost of the treatment. If Health Net denies the request for a referral, Health Net will send you a letter explaining the reason. The letter will also tell you what to do if you don't agree with this decision. This notice does not give you all the information you need about Health Net's Specialist referral policy. To get a copy of our policy, please contact us at the number shown on your Health Net ID card.

Changing Contracting Physician Groups

You may transfer to another contracting Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of the "Eligibility, Enrollment and Termination" section.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Copayment described in the "Schedule of Benefits and Copayments" section. You are completely financially responsible for medical care that the contracting Physician Group does not provide or authorize except for Medically Necessary care provided in an emergency. However, if you receive covered services at a contracted network health facility at which, or as a result of which, you receive services provided by a noncontracted provider, you will pay no more than the same cost-sharing you would pay for the same covered services received from a contracted network provider. You are also financially responsible for care that this Plan does not cover.

Questions

Call the Customer Contact Center with questions about this Plan at the number shown on your Health Net ID card.

Timely Access to Care

The California Department of Managed Health Care (DMHC) has issued regulations (California Code of Regulations, Title 28, Section 1300.67.2.2) with requirements for timely access to nonemergency Health Care Services.

Please contact Health Net 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.

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

Definitions Related to Timely Access to Care

Triage or Screening is the evaluation of a Member's health concerns and symptoms by talking to a doctor, nurse, or other qualified health care professional to determine the Member's urgent need for care.

Triage or Screening Waiting Time is the time it takes to speak by telephone with a doctor, nurse, or other qualified health care professional who is trained to screen or triage a Member who may need care and will not exceed 30 minutes.

Business Day is every official working day of the week. Typically, a business day is Monday through Friday, and does not include weekends or holidays.

Scheduling Appointments with Your Primary Care Physician

When you need to see your Primary Care Physician (PCP), call their office for an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net Member, and tell the receptionist when you would like to see your doctor. The receptionist will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your Physician as soon as possible.

This is a general idea of how many business days, as defined above, that you may need to wait to see your Primary Care Physician. Wait times depend on your condition and the type of care you need. You should get an appointment to see your PCP.

- **Nonurgent appointments with PCP:** within 10 business days of request for an appointment.
- **Urgent care appointment with PCP:** within 48 hours of request for an appointment.
- **Routine check-up/physical exam:** within 30 business days of request for an appointment.

Your Primary Care Physician may decide that it is okay to wait longer for an appointment as long as it does not harm your health.

Scheduling Appointments with Your Participating Mental Health Professional

When you need to see your designated Participating Mental Health Professional, call their office for an appointment. When you call for an appointment, identify yourself as covered through Health Net, and tell the receptionist when you would like to see your provider. The receptionist will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your provider as soon as possible.

This is a general idea of how many business days, as defined above, that you may need to wait to see a Participating Mental Health Professional:

- **Urgent care appointment with non-Physician behavioral health care provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization:** within 96 hours of request.

- **Urgent care appointment with non-Physician behavioral health care provider or behavioral health care Physician (psychiatrist) that does not require Prior Authorization:** within 48 hours of request.
- **Nonurgent appointment with behavioral health care Physician (psychiatrist):** within 15 business days of request.
- **Nonurgent appointment with non-Physician behavioral health care provider:** within 10 business days of request.
- **Nonurgent follow-up appointment with non-Physician mental health care provider (NPMH):** within 10 business days of request.
- **Non-life-threatening behavioral health emergency:** within 6 hours of request for an appointment.

Your Participating Mental Health Professional may decide that it is okay to wait longer for an appointment as long as it does not harm your health.

Scheduling Appointments with a Specialist for Medical and Surgical Services

Your Primary Care Physician is your main doctor who makes sure you get the care you need when you need it. Sometimes your Primary Care Physician will send you to a Specialist.

Once you get approval to receive the Specialist services, call the Specialist's office to schedule an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net Member, and tell the receptionist when you would like to see the Specialist. The Specialist's office will do their best to make your appointment at a time that works best for you.

This is a general idea of how many business days, as defined above, that you may need to wait to see the Specialist. Wait times for an appointment depend on your condition and the type of care you need. You should get an appointment to see the Specialist:

- **Nonurgent appointments with Specialists:** within 15 business days of request for an appointment.
- **Urgent care appointment:** with a Specialist or other type of provider that needs approval in advance - within 96 hours of request for an appointment.
- **Urgent care appointment:** with a Specialist or other type of provider that does not need approval in advance - within 48 hours of request for an appointment.

Scheduling Appointments for Ancillary Services

Sometimes your doctor will tell you that you need ancillary services such as lab, x-ray, therapy, and medical devices, for treatment or to find out more about your health condition.

Here is a general idea of how many business days, as defined above, that you may need to wait for the appointment:

- **Ancillary service appointment:** within 15 business days of request for an appointment.

Canceling or Missing Your Appointments

If you cannot go to your appointment, call the doctor's office right away. If you miss your appointment, call right away to reschedule your appointment. By canceling or rescheduling your appointment, you let someone else be seen by the doctor.

Triage and/or Screening/24-Hour Nurse Advice Line

As a Health Net Member, you have access to triage or screening services, 24 hours per day, 7 days per week. When you are sick or need urgent behavioral health care and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center or the 24-hour Nurse Advice Line at the number shown on your Health Net ID card, and select the Triage and/or Screening option to these services. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions. You can also call 988, the national suicide and mental health crisis hotline system.

If you have a life-threatening emergency, call "911" or go immediately to the closest emergency room. Use "911" only for true emergencies.

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL OR MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE IMMEDIATELY

In serious emergency situations: Call "**911**" or go to the nearest Hospital.

If your situation is not so severe: Call your Primary Care Physician or Physician Group or a Participating Mental Health Professional or, if you cannot call them or you need medical or mental health care right away, go to the nearest medical center or Hospital. You can also call 988, the national suicide and mental health crisis hotline system.

Your Physician Group and Health Net are available 24 hours a day, seven days a week, to respond to your phone calls regarding care that you believe is needed immediately. They will evaluate your situation and give you directions about where to go for the care you need.

Except in an emergency or other urgent circumstances:

- **Medical services:** Covered services of this Plan must be performed by your Physician Group or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group or Health Net.
- **Mental Health and Substance Use Disorders services:** Covered services of this Plan must be performed by your Participating Mental Health Professional or authorized by Health Net to be performed by others. You may use nonparticipating mental health providers only when authorized by Health Net.

If you are not sure whether you have an emergency or require urgent care, please contact Health Net at the number shown on your Health Net ID card. As a Health Net Member, you have access to triage or screening services, 24 hours per day, 7 days per week.

Urgently Needed Care within a 30-mile radius of your Physician Group and all non-Emergency Care - must be performed by your Physician Group or Participating Mental Health Professional or authorized by your Physician Group or Health Net in order to be covered. These services, if performed by others outside your Physician Group or our network of Participating Mental Health Professionals, will not be covered unless they are authorized by your Physician Group (medical) or Health Net (Mental Health and Substance Use Disorders).

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care (including care outside of California) - may be performed by your Physician Group or another

provider when your circumstances require it. Services by other providers will be covered if the facts demonstrate that you required Emergency Care or Urgently Needed Care. Authorization is not mandatory to secure coverage. See the "Definitions Related to Emergency and Urgently Needed Care" section below for the definition of Urgently Needed Care.

It is critical that you contact your Physician Group (medical) or Health Net (Mental Health and Substance Use Disorders) as soon as you can after receiving emergency services from others outside your Physician Group. Your Physician Group (medical) or Health Net (Mental Health and Substance Use Disorders) will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care. They will also advise you about how to obtain reimbursement for charges you may have paid.

Always present your Health Net ID card to the health care provider regardless of where you are. It will help them understand the type of coverage you have, and they may be able to assist you in contacting your Physician Group or Health Net.

After your medical problem (including Mental Health and Substance Use Disorders) no longer requires Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered Follow-Up Care.

Follow-Up Care services must be performed by your Physician Group (medical) or a Participating Mental Health Professional (Mental Health and Substance Use Disorders) and, if required, authorized by your Physician Group (medical) or Health Net (Mental Health and Substance Use Disorders), or it will not be covered.

Follow-Up Care after Emergency Care at a Hospital that is not contracted with Health Net: If you are treated for Emergency Care at a Hospital that is not contracted with Health Net, Follow-Up Care must be authorized by Health Net, or it will not be covered. If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the noncontracted Hospital must contact Health Net to obtain timely authorization. If Health Net determines that you may be safely transferred to a Hospital that is contracted with Health Net and you refuse to consent to the transfer, the noncontracted Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the noncontracted Hospital is unable to determine the contact information at Health Net in order to request Prior Authorization, the noncontracted Hospital may bill you for such services.

Definitions Related to Emergency and Urgently Needed Care

Please refer to the "Definitions" section for definitions of Emergency Care, Emergency Medical Condition, Psychiatric Emergency Medical Condition and Urgently Needed Care.

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency Care or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the drug less any required Copayment or Coinsurance shown in the "Schedule of Benefits and Copayments" section. You will have to pay for the Prescription Drug when it is dispensed.

To be reimbursed, you must file a claim with Health Net. Call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com to obtain claim forms and information.

Note(s):

The Prescription Drugs portion of the "Exclusions and Limitations" section and the requirements of the Essential Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy.

Pediatric Vision Services

In the event you require emergency pediatric vision care, please contact a Health Net Participating Vision Provider to schedule an immediate appointment. Most Participating Vision Providers are available during extended hours and weekends and can provide services for urgent or unexpected conditions that occur after-hours.

Pediatric Dental Services

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

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

Your reimbursement from us for emergency pediatric dental services, if any, is limited to the extent the treatment you received directly relates to emergency pediatric dental services - i.e. to evaluate and stabilize the dental condition. All reimbursements will be allocated in accordance with your Plan benefits, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any Hospital or outpatient care facility that are not related to treatment of the actual dental condition are not covered benefits.

Gold $40

SCHEDULE OF BENEFITS AND COPAYMENTS

The following schedule shows the Copayments (fixed dollar and percentage amounts) that you must pay for this Plan's covered services and supplies.

You must pay the stated fixed dollar Copayments at the time you receive services. Percentage Copayments are usually billed after services are received.

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to the "Out-of-Pocket Maximum" section for more information.

See "COVID-19 Outpatient Services" in the "Covered Services and Supplies" section for additional coverage information about screening, diagnostic testing, therapeutics, and vaccinations for COVID-19 and its variants.

Covered services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as covered services delivered in-person. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center (Medical care other than Mental Health and Substance Use Disorders)

	Copayment
Use of emergency room facility	$350
Emergency room professional services	$0
Use of urgent care center (facility and professional services)	$40

Copayment Exception(s):

If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.

For Emergency Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this Plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center (Mental Health and Substance Use Disorders)

	Copayment
Use of emergency room facility	$350
Emergency room professional services	$0
Use of urgent care center (facility and professional services)	$40

Copayment Exception(s):

If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.

For Emergency Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this Plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Ambulance Services (Medical care other than Mental Health and Substance Use Disorders)

	Copayment
Ground ambulance	$350
Air ambulance	$350

Note(s):

For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Services and Supplies" section, and the "Exclusions and Limitations" section.

Ambulance Services (Mental Health and Substance Use Disorders)

	Copayment
Ground ambulance	$350
Air ambulance	$350

Note(s):

For more information on ambulance services coverage, refer to the "Ambulance Services" portions of the "Covered Services and Supplies" section, and the "Exclusions and Limitations" section.

Office Visits

	Copayment
Visit to Physician, Physician Assistant, Nurse Practitioner or Podiatrist at a contracting Physician Group	$40
Specialist consultation	$60
Visit to CVS MinuteClinic*	$30
Primary Care Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$40
Specialist visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$60
Hearing examination for diagnosis or treatment	$40
Vision examination for diagnosis or treatment (ages 19 and older) by an Optometrist**	$40
Vision examination for diagnosis or treatment (ages 19 and older) by an ophthalmologist**	$60
Annual physical examination***	Not covered
Telehealth consultation through the Select Telehealth Services Provider****	$0

Note(s):

Self-referrals are allowed for obstetrician and gynecological services, and reproductive and sexual Health Care Services. Refer to the "Obstetrician and Gynecologist (OB/GYN) Self-Referral" and "Self-Referral for Reproductive and Sexual Health Care Services" portions of the "Covered Services and Supplies" section.

The office visit Copayment applies to visits to your Primary Care Physician. The Specialist consultation Copayment applies to services that are performed by a Member Physician who is not your Primary Care Physician. When a Specialist is your Primary Care Physician, the office visit Copayment will apply to visits to that Physician, except as noted below for certain Preventive Care Services. See "Primary Care Physician" in the "Definitions" section for information about the types of Physicians you can choose as your Primary Care Physician.

* Specialist referrals following care from CVS MinuteClinic must be obtained through the contracting Physician Group. Preventive Care Services through the CVS MinuteClinic are subject to the Copayment shown below under "Preventive Care Services."

** See "Pediatric Vision Services" for details regarding pediatric vision care services for ages younger than 19.

***For nonpreventive purposes, such as taken to obtain employment or administered at the request of a third party, such as a school, camp, or sports organization. For annual preventive physical examinations, see "Preventive Care Services" below.

****The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Preventive Care Services

	Copayment
Preventive Care Services*	$0

Note(s):

Covered services include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breastfeeding support and supplies (including one breast pump per pregnancy), and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Covered Services and Supplies" section for details.

If you receive any other covered services in addition to Preventive Care Services during the same visit, you will also pay the applicable Copayment for those services.

* Cervical cancer and human papillomavirus (HPV) screenings, and preventive colonoscopies will be covered at no cost.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Note(s):

The above Copayment applies to professional services only. Care that is rendered in a Hospital or Skilled Nursing Facility is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" and "Skilled Nursing Facility Services" headings to determine any additional Copayments that may apply.

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$60
Allergy injection services	$40
Allergy serum	$40
Immunizations for occupational purposes or foreign travel	Not covered
Injections	
Office based injectable medications - administration (per dose)*	$0
Office based injectable medications - injected substance (per dose)*	$40

Note(s):

Immunizations that are part of Preventive Care Services are covered under "Preventive Care Services" in this section.

* Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If you need to have the provider administer the Specialty Drug, you will need to obtain the Specialty Drug through our contracted specialty pharmacy vendor and bring it with you to the Physician's office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted specialty pharmacy vendor. Please refer to the "Tier 4 Drugs (Specialty Drugs)" portion of this "Schedule of Benefits and Copayments" section for the applicable Copayment.

Rehabilitation and Habilitation Therapy

	Copayment
Physical therapy	$40
Occupational therapy	$40
Speech therapy	$40
Pulmonary rehabilitation therapy	$40
Cardiac rehabilitation therapy	$40
Habilitative therapy	$40

Note(s):

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation and Habilitation Therapy" in the "Exclusions and Limitations" section.

Care for Conditions of Pregnancy

	Copayment
Prenatal care and preconception visits*	$40
Postnatal office visit*	$40
Specialist consultation regarding pregnancy	$60
Newborn care office visit (birth through 30 days)*	$40
Physician visit to the mother or newborn at a Hospital**	$0
Normal delivery, including cesarean section	$0
Circumcision of newborn (birth through 30 days)***	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0

Note(s):

The above Copayments apply to professional services only. Services that are rendered in a Hospital or in an outpatient surgery setting are also subject to the applicable inpatient and outpatient professional and facility Copayments. Look under the "Hospital Visits by Physician," "Other Professional Services," "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply. Genetic testing is covered as a laboratory service as shown under the "Other Professional Services" heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.

Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered as shown under "Prostheses" in the "Medical Supplies" section below.

* Termination of pregnancy and related services are covered in full. Prenatal, postnatal, and newborn care that are Preventive Care Services are covered in full. See "Preventive Care Services" above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" under the "Covered Services and Supplies" section.

** One Copayment per visit.

***Circumcisions for Members age 31 days and older are covered when Medically Necessary under outpatient surgery. Refer to "Other Professional Services" and "Outpatient Facility Services" for applicable Copayments.

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male	$0
Reversal of sterilization	Not covered

Note(s):

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

Other Professional Services

	Copayment
Surgery	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$40
Assistance at surgery	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$40
Administration of anesthetics	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$40
Chemotherapy	$40
Radiation therapy	$40
Laboratory services	$40
Diagnostic imaging (including x-ray) services	$50
CT, SPECT, MRI, MUGA and PET	$350
Medical social services	$0
Patient education*	$0
Nuclear medicine (use of radioactive materials)	$40
Renal dialysis	$40
Organ, tissue, or stem cell transplants	See note below**
Infusion therapy in a home, outpatient or office setting	40%

Note(s):

The above Copayments apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply.

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

* Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care and have no cost sharing; however, if other medical services are provided at the same time that are not solely for the purpose of covered preventive care, the appropriate related Copayment will apply.

** Applicable Copayment requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment will apply. Refer to the "Organ, Tissue and Stem Cell Transplants" portion of the "Covered Services and Supplies" section for details.

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers, including face masks and tubing	40%
Orthotics (such as bracing, supports and casts)	40%

Diabetic equipment* 40%
Diabetic footwear 40%
Prostheses (internal or external)** 40%
Blood or blood products, except for drugs used to treat hemophilia, including blood factors $0
Drugs used to treat hemophilia, including blood factors*** 30%
(up to a $250 maximum out-of-pocket cost per day)

Note(s):

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section. For additional information, please refer to the "Preventive Care Services" provision in the "Covered Services and Supplies" section.

If the retail charge for the medical supply is less than the applicable Copayment, you will only pay the retail charge.

* Corrective Footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Services and Supplies" section.

** Includes coverage for Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank. Prostheses also include coverage of ostomy and urological supplies. See the "Ostomy and Urological Supplies" portion of the "Covered Services and Supplies" section.

***Drugs for the treatment of hemophilia, including blood factors have a Copayment maximum of $250 per day. They are also covered as a Tier 4 Drug (Specialty Drug) under the Prescription Drug benefit.

Home Health Care Services

	Copayment
Home Health Care Services	$40 per visit

Limitation(s):

Home Health Care Services have a Calendar Year maximum limit of 100 visits.

Hospice Services

	Copayment
Hospice care	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$750 per day (5-day maximum Copayment per admission)

Note(s):

The above Copayment applies to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the "Hospital Visits by Physician,"

"Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional Copayments that may apply.

The above Copayment for inpatient Hospital services or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Copayment for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.

Outpatient Facility Services

	Copayment
Outpatient facility services (other than surgery)	40%
Outpatient surgery (surgery performed in a Hospital outpatient setting only)	$1,200

Note(s):

The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments or Coinsurance. Look under the "Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional Copayments that may apply.

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services or physical therapy are subject to the same Copayment which is required when these services are performed at your Physician's office.

Look under the headings for the various services such as office visits, rehabilitation, and other professional services to determine any additional Copayments that may apply.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment applicable for outpatient facility services (other than surgery).

Use of a Hospital emergency room appears in the first item at the beginning of this section.

Outpatient Surgical Center Services

	Copayment
Outpatient facility services (other than surgery)	40%
Surgery performed in an Outpatient Surgical Center	$480

Note(s):

The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments. Look under the "Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional Copayments that may apply.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic

endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment applicable for outpatient facility services (other than surgery).

Skilled Nursing Facility Services

	Copayment
Room and board in a semi-private room with ancillary (additional) services	$25 per day

Mental Health and Substance Use Disorder Benefits

	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)*	$40
Outpatient group therapy session	$20
Outpatient services other than an office visit/professional consultation (including psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, partial hospitalization/day treatment, therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day and other outpatient services including, but not limited to, laboratory services or rehabilitation when provided for a Mental Health or Substance Use Disorder condition)**	$40
Participating Mental Health Professional visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net)	$40
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$750 per day (5-day maximum Copayment per admission)
Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$750 per day (5-day maximum Copayment per admission)

Copayment Exception(s):

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

** Medically Necessary services for Mental Health and Substance Use Disorders are not subject to the visit limitations shown elsewhere in this "Schedule of Benefits and Copayments" section.

Note(s):

The applicable Copayment for outpatient services is required for each visit.

Prescription Drugs

Refer to the Notes below for clarification of your financial responsibility regarding Copayment.

Retail Pharmacy (up to a 30-day supply)

	Copayment
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$15
Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost	$50
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier	$70
Preventive drugs and contraceptives	$0

Tier 4 Drugs (Specialty Drugs) (up to a 30-day supply)

Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply	30% (up to a maximum of $250 per prescription)

Maintenance Drugs through the Mail Order Program (up to a 90-day supply)

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$30
Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost	$125
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier	$175
Preventive drugs and contraceptives	$0

Note(s):

To obtain specific benefit and drug information, including your cost for a specific drug at your preferred pharmacy, please log into your secure Member portal or call the Customer Contact Center at the number on your Health Net ID card.

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

For information about Health Net's Essential Drug List, please call the Customer Contact Center at the telephone number on your ID card or visit our website at www.healthnet.com to view the Essential Drug List.

Percentage Copayments will be based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription for covered Prescription Drugs.

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

You will be charged a Copayment for each Prescription Drug Order.

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions, and limitations, please refer to the "Prescription Drugs" portions of the "Covered Services and Supplies" and the "Exclusions and Limitations" sections.

Prior Authorization:

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of the "Covered Services and Supplies" section for a description of Prior Authorization requirements or visit our website at www.healthnet.com to obtain a list of drugs that require Prior Authorization.

A Physician must obtain Health Net's Prior Authorization for coverage of Brand Name Drugs that have generic equivalents.

Copayment Exception(s):

If the pharmacy's or the mail order administrator's cost of the prescription is less than the applicable Copayment, you will only pay the pharmacy's cost of the prescription or the mail order administrator's cost of the prescription.

Preventive Drugs and Contraceptives:

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. Covered preventive drugs include over-the-counter drugs and Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Forces A and B recommendations, including smoking cessation drugs. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Up to a 12-consecutive –calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section for additional details.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

Mail Order:

A 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

Maintenance Drugs on the Health Net Maintenance Drug List may also be obtained at a CVS retail pharmacy under the mail order program benefits.

Diabetic Supplies:

Diabetic supplies (blood glucose testing strips, lancets, disposable needles, and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged).

When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for up to a 30-day period.

Tier 4 Drugs (Specialty Drugs):

Tier 4 Drugs (Specialty Drugs) are specific Prescription Drugs used to treat complex or chronic conditions and require close monitoring or injectable drugs administered by the patient. Tier 4 Drugs (Specialty Drugs) are identified in the Essential Drug List with "SP," require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 Drugs (Specialty Drugs) are not available through mail order.

Acupuncture Services

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*.

Office Visits	Copayment
New patient examination	$15
Each subsequent visit	$15
Re-examination visit	$15
Second opinion	$15

Note(s):

If the re-evaluation occurs during a subsequent visit, only one Copayment will be required.

Limitation(s):

Acupuncture Services, typically provided only for the treatment of Nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain, are covered when Medically Necessary.

Pediatric Vision Services

All of the following services must be provided by a Health Net Participating Vision Provider in order to be covered. Refer to the "Pediatric Vision Services" portion of "Exclusions and Limitations" for limitation on covered pediatric vision services.

The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

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

Professional Services	Copayment
Routine eye examination with dilation	$0
Examination for contact Lenses	
Standard contact lens fit and follow-up	$0*
Premium contact lens fit and follow-up	$0*

Limitation(s):

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

Note(s):

Examination for contact Lenses is in addition to the Member's vision examination. There is no additional Copayment for contact lens follow-up visit after the initial fitting exam.

Benefits may not be combined with any discounts, promotional offerings, or other group benefit plans. Allowances are one time use benefits. No remaining balance.

Standard contact lens includes soft, spherical, and daily wear contact Lenses.

Premium contact lens includes toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable contact Lenses.

Materials (including frames and Lenses)	Copayment
Provider selected frames (one every 12 months)	$0
Standard Eyeglass Lenses (one pair every 12 months)	$0
• Single vision, bifocal, trifocal, lenticular	
• Glass or plastic, including polycarbonate	
Optional Lenses and treatments including:	$0
• UV treatment	
• Tint (fashion & gradient & glass-grey)	
• Standard plastic scratch coating	
• Photochromic/transitions plastic	
• Standard and premium anti-reflective coating	
• Polarized	
• Standard and premium progressive lens	

- Hi-index Lenses
- Blended segment Lenses
- Intermediate vision Lenses

Provider selected contact Lenses (in lieu of Eyeglass Lenses).....$0

- Standard (hard) contacts, 1 contact per eye per every 12 months
- Monthly contacts (six-month supply)
- Bi-weekly contacts (six-month supply)
- Dailies (three-month supply)
- Medically Necessary*

* Contact Lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Subnormal or low vision services and aids - supplemental testing/exam, Follow-Up Care, and low vision aids $0

Medically Necessary Contact Lenses

Coverage of Medically Necessary contact Lenses is subject to Medical Necessity. 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. See the "Pediatric Vision Services" portion of "Exclusions and Limitations" for details of limitations.

Contact Lenses for Conditions of Aphakia

Special contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact Lenses for that eye during the same Calendar Year. For adults age 19 and older, see the "Durable Medical Equipment" portion of "Covered Services and Supplies" for coverage details.

Pediatric Dental Services

Except as otherwise provided in the "Pediatric Dental Services" portion of the "Covered Services and Supplies," and "Pediatric Dental Services" portion of "Introduction to Health Net," all of the following services must be provided by your selected Health Net participating primary dental provider in order to be covered. Refer to the "Pediatric Dental Services" portion of "Exclusions and Limitations" for limitations on covered pediatric dental services.

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

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

If there are no network dental providers available within the access standards for a given zip code, the Member can ask to see an out-of-network dental provider at the in-network cost share by calling Customer Service at **(866) 249-2382**. If we determine that an in-network dental provider is not within the access standards for your zip code, the Plan will verbally approve the request during the Customer Service call and the Member will only be responsible for the in-network dental cost share.

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

Code	Service	Member Copayment
	Diagnostic	
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12-month period	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays intraoral - comprehensive series (including bitewings) limited to once per provider every 24 months	No Charge
D0220	X-rays intraoral - periapical first film limited to a maximum of 20 periapical in a 12-month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapical taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical in a 12-month period	No Charge
D0230	X-rays intraoral - periapical each additional film limited to a maximum of 20 periapical in a 12-month period	No Charge
D0240	X-rays intraoral - occlusal film limited to 2 in a 6-month period	No Charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector - first film	No Charge
D0251	Extraoral posterior dental radiographic image	No Charge
D0270	X-rays bitewing - single film limited to once per date of service	No Charge

Code	Service	Member Copayment
D0272	X-rays bitewings - two films limited to once every 6 months	No Charge
D0273	X-rays bitewings - three films	No Charge
D0274	X-rays bitewings - four films – limited to once every 6 months	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No Charge
D0322	Tomographic survey limited to twice in a 12-month period	No Charge
D0330	Panoramic film limited to once in a 36-month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)	No Charge
D0340	2D cephalometric radiographic image limited to twice in a 12-month period per provider	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0396	3D printing of a 3D dental surface scan	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0701	Panoramic radiographic image – image capture only	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No Charge

Code	Service	Member Copayment
D0706	Intraoral – occlusal radiographic image – image capture only	No Charge
D0707	Intraoral – periapical radiographic image – image capture only	No Charge
D0708	Intraoral – bitewing radiographic image – image capture only	No Charge
D0709	Intraoral – comprehensive series of radiographic images – image capture only	No Charge
D0801	3D intraoral surface scan - direct	No Charge
D0802	3D dental surface scan - indirect	No Charge
D0803	3D facial surface scan - direct	No Charge
D0804	3D facial surface scan - indirect	No Charge
D0999	Office visit fee - per visit (unspecified diagnostic procedure, by report)	No Charge
	Preventive	
D1110	Prophylaxis - adult limited to once in a 12-month period	No Charge
D1120	Prophylaxis - child limited to once in a 6-month period	No Charge
D1206	Topical fluoride varnish limited to once in a 6-month period	No Charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6-month period	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	Interim caries arresting medicament application - per tooth	No Charge

Code	Service	Member Copayment
D1355	Caries preventive medicament application – per tooth	No Charge
D1510	Space maintainer - fixed - unilateral limited to once per quadrant	No Charge
D1516	Space maintainer – fixed – bilateral, maxillary	No Charge
D1517	Space maintainer – fixed – bilateral, mandibular	No Charge
D1520	Space maintainer - removable - unilateral limited to once per quadrant	No Charge
D1526	Space maintainer – removable – bilateral, maxillary	No Charge
D1527	Space maintainer – removable – bilateral, mandibular	No Charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No Charge
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Charge
D1557	Removal of fixed bilateral space maintainer - maxillary	No Charge
D1558	Removal of fixed bilateral space maintainer - mandibular	No Charge
D1575	Distal shoe space maintainer - fixed - unilateral -per quadrant	No Charge
	Restorative	
D2140	Amalgam - one surface, primary limited to once in a 12-month period	$25
D2140	Amalgam - one surface, permanent limited to once in a 36-month period	$25
D2150	Amalgam - two surfaces, primary limited to once in a 12-month period	$30
D2150	Amalgam - two surfaces, permanent limited to once in a 36-month period	$30
D2160	Amalgam - three surfaces, primary limited to once in a 12-month period	$40
D2160	Amalgam - three surfaces, permanent limited to once in a 36-month period	$40

Code	Service	Member Copayment
D2161	Amalgam - four or more surfaces, primary limited to once in a 12-month period	$45
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36-month period	$45
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12-month period	$30
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36-month period	$30
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12-month period	$45
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36-month period	$45
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12-month period	$55
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36-month period	$55
D2335	Resin-based composite - four or more surfaces (anterior) primary limited to once in a 12-month period	$60
D2335	Resin-based composite - four or more surfaces (anterior) permanent limited to once in a 36-month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12-month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36-month period	$50
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12-month period	$30
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36-month period	$30
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12-month period	$40
D2392	Resin-based composite – two surfaces, posterior; permanent limited to once in a 36-month period	$40
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12-month period	$50
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36-month period	$50

Code	Service	Member Copayment
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12-month period	$70
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36-month period	$70
D2710	Crown - resin-based composite (indirect) limited to once in a 5-year period	$140
D2712	Crown – ¾ resin-based composite (indirect) limited to once in a 5-year period	$190
D2721	Crown - resin with predominantly base metal limited to once in a 5-year period	$300
D2740	Crown - porcelain/ceramic limited to once in a 5-year period	$300
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5-year period	$300
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5-year period	$300
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5-year period	$310
D2791	Crown - full cast predominantly base metal limited to once in a 5-year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12-month period	$95
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12-month period	$65
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36-month period	$75
D2932	Prefabricated resin crown, primary limited to once in a 12-month period	$75

Code	Service	Member Copayment
D2932	Prefabricated resin crown, permanent limited to once in a 36-month period	$75
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12-month period	$80
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36-month period	$80
D2940	Placement of interim direct restoration limited to once per tooth in a 12-month period	$25
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention - per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post - same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	$35
D2976	Band stabilization - per tooth	$40
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider	$50
D2989	Excavation of a tooth resulting in the determination of nonrestorability	$50
D2991	Application of hydroxyapatite regeneration medicament - per tooth	No Charge
D2999	Unspecified restorative procedure, by report	$40
	Endodontics	
D3110	Pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap - indirect (excluding final restoration)	$25

Code	Service	Member Copayment
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	$40
D3221	Pulpal debridement primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; nonsurgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy - anterior	$240
D3347	Retreatment of previous root canal therapy - premolar	$295
D3348	Retreatment of previous root canal therapy - molar	$350
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	$85
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth	$45
D3410	Apicoectomy - anterior	$240
D3421	Apicoectomy - premolar (first root)	$250

Code	Service	Member Copayment
D3425	Apicoectomy - molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350
D3430	Retrograde filling - per root	$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	$80
D3471	Surgical repair of root resorption - anterior	$160
D3472	Surgical repair of root resorption – premolar	$160
D3473	Surgical repair of root resorption – molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
	Periodontics	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$50
D4249	Clinical crown lengthening - hard tissue	$165
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant– once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	$30

Code	Service	Member Copayment
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist) once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)	$15
D4999	Unspecified periodontal procedure, by report	$350
	Prosthodontics, removable	
D5110	Complete denture - maxillary limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	$300
D5120	Complete denture - mandibular limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	$300
D5130	Immediate denture - maxillary	$300
D5140	Immediate denture - mandibular	$300
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$300
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	$335

Code	Service	Member Copayment
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12-month period	$20
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12-month period	$20
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12-month period	$20
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12-month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth - complete denture per tooth limited to a maximum of four, per arch, per date of service; twice per arch in a 12-month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12-month period	$50
D5640	Replace missing or broken teeth - partial denture - per tooth - limited to maximum of four, per arch, per date of service; twice per arch in a 12-month period	$35
D5650	Add tooth to existing partial denture limited - per tooth - to a maximum of three, per date of service; once per tooth	$35

Code	Service	Member Copayment
D5660	Add clasp to existing partial denture - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12-month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period	$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period	$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period	$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period	$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36-month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture - complete maxillary	$300
D5864	Overdenture - partial maxillary	$300
D5865	Overdenture - complete mandibular	$300
D5866	Overdenture - partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
	Maxillofacial Prosthetics	

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

Code	Service	Member Copayment
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
	Implant Services	
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Surgical access to an implant body (second) stage implant surgery	$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	$350
D6013	Surgical placement of mini-implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315

Code	Service	Member Copayment
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain crown (porcelain fused to high noble alloys)	$335
D6067	Implant supported metal crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	$330
D6077	Implants supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown - porcelain fused to noble alloys	$335

Code	Service	Member Copayment
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335
D6085	Interim implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown - noble alloys	$340
D6088	Implant supported crown - titanium and titanium alloys	$340
D6089	Accessing and retorquing loose implant screw - per screw	$60
D6090	Repair of implant/abutment supported prosthesis	$65
D6091	Replacement of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown - titanium and titanium alloys	$295
D6096	Removal of broken implant retaining screw	$60
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$110
D6105	Removal of implant body not requiring bone removal or flap elevation	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350

Code	Service	Member Copayment
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD - noble alloys	$350
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30
D6190	Radiographic/surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD titanium and titanium alloys	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95
D6198	Remove interim implant component	$110
D6199	Unspecified implant procedure, by report	$350
	Prosthodontics, fixed	
D6211	Pontic - cast predominantly base metal limited to once in a 5-year period	$300
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5-year period	$300

Code	Service	Member Copayment
D6245	Pontic - porcelain/ceramic limited to once in a 5-year period	$300
D6251	Pontic - resin with predominantly base metal limited to once in a 5-year period	$300
D6721	Retainer crown - resin predominantly base metal – denture limited to once in a 5-year period	$300
D6740	Retainer crown - porcelain/ceramic limited to once in a 5-year period	$300
D6751	Retainer crown -porcelain fused to predominantly base metal limited to once in a 5-year period	$300
D6781	Retainer crown - ¾ cast predominantly base metal limited to once in a 5-year period	$300
D6783	Retainer crown ¾ porcelain/ceramic limited to once in a 5-year period	$300
D6784	Retainer crown - ¾ titanium and titanium alloys	$300
D6791	Retainer crown - full cast predominantly base metal limited to once in a 5-year period	$300
D6930	Recement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
	Oral Maxillofacial Prosthetics	
D7111	Extraction, coronal remnants - primary tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth - soft tissue	$95
D7230	Removal of impacted tooth - partially bony	$145
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7252	Partial extraction for immediate implant placement	$80

Code	Service	Member Copayment
D7259	Nerve dissection	$280
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7284	Excisional biopsy of minor salivary glands	$115
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service	$85
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$65
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) limited to once in a 5-year period per arch	$350

Code	Service	Member Copayment
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7509	Marsupialization of odontogenic cyst	$180

Code	Service	Member Copayment
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	$75
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250
D7630	Mandible - open reduction (teeth immobilized, if present)	$350
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch - open reduction	$350
D7660	Malar and/or zygomatic arch - closed reduction	$350
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170
D7671	Alveolus - open reduction, may include stabilization of teeth	$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla - open reduction	$110
D7720	Maxilla - closed reduction	$180
D7730	Mandible - open reduction	$350
D7740	Mandible - closed reduction	$290
D7750	Malar and/or zygomatic arch - open reduction	$220

Code	Service	Member Copayment
D7760	Malar and/or zygomatic arch - closed reduction	$350
D7770	Alveolus - open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Nonarthroscopic lysis and lavage	$150
D7872	Arthroscopy - diagnosis, with or without biopsy	$350
D7873	Arthroscopy - lavage and lysis of adhesions	$350
D7874	Arthroscopy - disc repositioning and stabilization	$350
D7875	Arthroscopy - synovectomy	$350
D7876	Arthroscopy - discectomy	$350
D7877	Arthroscopy - debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture - up to 5 cm	$55
D7912	Complicated suture - greater than 5 cm	$130

Code	Service	Member Copayment
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350
D7940	Osteoplasty - for orthognathic deformities	$160
D7941	Osteotomy - mandibular rami	$350
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy - segmented or subapical	$275
D7945	Osteotomy - body of mandible	$350
D7946	LeFort I (maxilla - total)	$350
D7947	LeFort I (maxilla - segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350
D7949	LeFort II or LeFort III - with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7961	Buccal/labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
D7979	Nonsurgical sialolithotomy	$155
D7980	Surgical sialolithotomy	$155

Code	Service	Member Copayment
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft - mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
	Orthodontics	
Orthodontics	Medically Necessary banded case (The Copayment applies to a Member's course of treatment as long as that Member remains enrolled in this Plan.)	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8091	Comprehensive orthodontic treatment with orthognathic surgery	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance - maxillary	
D8697	Repair of orthodontic appliance - mandibular	
D8698	Recement or re-bond fixed retainer - maxillary	
D8699	Recement or re-bond fixed retainer - mandibular	
D8701	Repair of fixed retainer, includes reattachment - maxillary	

Code	Service	Member Copayment
D8702	Repair of fixed retainer, includes reattachment - mandibular	
D8703	Replacement of lost or broken retainer - maxillary	
D8704	Replacement of lost or broken retainer - mandibular	
D8999	Unspecified orthodontic procedure, by report	
	Adjunctive General Services	
D9110	Palliative treatment of dental Pain - per visit	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45
D9222	Deep sedation/general anesthesia - first 15 minutes	$45
D9223	Deep sedation/general anesthesia– each subsequent 15 minute increment	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$60
D9248	Nonintravenous conscious sedation	$65
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician	$50
D9311	Consultation with a medical health professional	No Charge
D9410	House/extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20

Code	Service	Member Copayment
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	$20
D9930	Treatment of complications – post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis – mounted case limited to once in a 12-month period	$120
D9951	Occlusal adjustment – limited. Limited to once in a 12-month period per quadrant	$45
D9952	Occlusal adjustment – complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)	$210
D9995	Teledentistry - synchronous; real-time encounter. Limited to twice in a 12-month period	No Charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12-month period	No Charge
D9997	Dental case management - patients with special health care needs	No Charge
D9999	Unspecified adjunctive procedure, by report	No Charge

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for covered services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Copayments you pay for covered services and supplies under this *Evidence of Coverage*, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans) in any one Calendar Year equals the "Out-of-Pocket Maximum" amount, no payment for covered services and benefits may be imposed on any Member, except as described in "Exceptions to OOPM" below.

The OOPM amounts for this Plan are:

One Member $7,500
Family (two or more Members).....$15,000

Exception(s) to OOPM

The following expenses will not be counted to the OOPM, nor will these expenses be paid at 100% after the Out-of-Pocket Maximum is reached:

- Your payments for services or supplies that this Plan does not cover will not be applied to the OOPM amount, including services from a CVS MinuteClinic that are not otherwise covered under this Plan. Please refer to the "Exclusions and Limitations" section for additional information.

How the OOPM Works

Keep a record of your payment for covered services and supplies.

- If an individual Member pays amounts for covered services and supplies in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder 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 until either (a) the aggregate of such Copayments paid by the family reaches the family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services and supplies paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.
- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services and supplies for yourself that would otherwise apply to your individual OOPM, but exceeds the above stated OOPM amount for one Member, will be refunded to you by Health Net and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the family OOPM.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also be notified by us when you have reached your OOPM amount for the Calendar Year. You can also obtain an update on your OOPM accumulation by calling the Customer Contact Center at the telephone number on your ID card. Please keep a copy of all receipts and canceled checks for costs for covered services and supplies as proof of payments made.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

The covered services and supplies of this Plan are available to eligible employees (Subscribers) as long as they live in the continental United States; either work or live in the Health Net Service Area; are full-time paid on a salary/hourly basis (not 1099. commissioned or substitute) and are nonseasonal employees working the minimum number of hours per week as specified in the Group Application; and meet any additional eligibility requirements of the Group and mutually agreed upon by Health Net:

Covered services and supplies of this Plan are also available to the following Family Members of the Subscriber who meet any eligibility requirements of the Group or as mutually agreed upon with Health Net:

- Spouse: The Subscriber's lawful spouse as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner as defined in the "Definitions" section.)
- Children: The children of the Subscriber or their spouse (including legally adopted children, stepchildren and wards, as defined in the following provision).
- Wards: Children for whom the Subscriber or their spouse is a court-appointed guardian.

Children of the Subscriber or spouse who are the subject of a Medical Child Support Order, according to state or federal law, are eligible even if they live outside the Health Net Service Area. Coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care.

The Subscriber and any Family Members of the Subscriber who reside outside the Health Net Service Area may enroll based on the Subscriber's work address that is within the Health Net Service Area. If you choose a Physician Group based on its proximity to the Subscriber's work address, you will need to travel to that Physician Group for any nonemergency or nonurgent care that you receive. Additionally, some Physician Groups may decline to accept assignment of a Member whose home or work address is not close enough to the Physician Group to allow reasonable access to care.

Age Limit for Children

Each child is eligible until the age of 26 (the limiting age).

Disabled Child

Children who reach age 26 are eligible to continue coverage if ***all*** of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

If you are *enrolling* a disabled child for new coverage, you must provide Health Net with proof of incapacity and dependency within 60 days of the date you receive a request for such information about the Dependent child from Health Net. The child must have been continuously covered as a Dependent of the Subscriber or spouse under a previous group health plan at the time the child reached the age limit.

Health Net must provide you notice at least 90 days prior to the date your enrolled child reaches the age limit at which the Dependent child's coverage will terminate. You must provide Health Net with proof of your child's incapacity and dependency within 60 days of the date you receive such notice from Health Net in order to continue coverage for a disabled child past the age limit.

You must provide the proof of incapacity and dependency at no cost to Health Net.

Health Net may require proof of continuing incapacity and dependency. If so, Health Net will follow these guidelines:

- Within the first two years following the child's reaching the age limit, you may be asked to provide proof as may be required by Health Net.
- After this two-year period, Health Net may require proof no more frequently than once a year.

A disabled child may remain covered by this Plan for as long as they remain incapacitated and continues to meet the eligibility criteria described above.

How to Enroll for Coverage

Notify the Group that you want to enroll an eligible person. The Group will send the request to Health Net according to current procedures.

Employee

Eligible employees must enroll within 30 days of the date they first become eligible for this Plan. Eligible Family Members may also be enrolled at this time (see "Who Is Eligible for Coverage" above in this section).

If enrollment of the eligible employee or eligible Family Members does not occur within this time period, enrollment may be carried out as stated below in the "Late Enrollment Rule" provision of this section.

The employee may enroll on the earlier of the following dates:

- When the Plan takes effect, if the employee is eligible on that date.
- When any waiting or probationary period required by the Group has been completed.

Eligible employees who enroll in this Plan are called Subscribers.

Newly Acquired Dependents

You are entitled to enroll newly acquired Dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse (and your spouse's eligible children) within 60 days of the date of marriage. Coverage begins on the first day of the month following the date the application for coverage is received.

Domestic Partner: If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may enroll your new Domestic Partner (and their eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 60 days of the formation of the domestic partnership according to your Group's eligibility rules.

Coverage begins on the first day of the month following the date the application for coverage is received.

Newborn Child: A child newly born to the Subscriber or their spouse will automatically be covered for 31 days (including the date of birth). If you do not enroll the newborn within 60 days (including the date of birth), they are covered for only the 31 days starting on and including the day of birth.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Adopted Child: A newly adopted child, or a child who is being adopted, becomes eligible on the date of adoption or the date of placement for adoption, as requested by the adoptive parent.

Coverage begins automatically and will continue for 30 days from the date of eligibility. The child will be assigned to the Subscriber's Physician Group. You must enroll the child before the 60th day for coverage to continue beyond the first 30 days. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Health Net will require written proof of the right to control the child's health care when you enroll them.

Legal Ward (Guardianship): If the Subscriber or spouse becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 60 days of the effective date of the guardianship. Coverage will begin on the first day of the month after Health Net receives the enrollment request.

Health Net will require proof that the Subscriber or spouse is the court-appointed legal guardian.

In Hospital on Your Effective Date

If you are confined in a Hospital or Skilled Nursing Facility on the Effective Date of coverage, this Plan will cover the remainder of that confinement only if you inform the Customer Contact Center upon your Effective Date about the confinement.

Health Net and your selected Physician Group will consult with your attending Physician, and may transfer you to a participating facility when medically appropriate.

Totally Disabled on Your Effective Date

Generally, under the federal Health Insurance Portability and Accountability Act, Health Net cannot deny you benefits due to the fact that you are totally disabled on your Effective Date. However, if upon your Effective Date you are totally disabled and pursuant to state law you are entitled to an extension of benefits from your prior group health plan, benefits of this Plan will be coordinated with benefits payable by your prior group health plan, so that not more than 100% of covered expenses are provided for services rendered to treat the disabling condition under both plans.

For the purposes of coordinating benefits under this *Evidence of Coverage*, if you are entitled to an extension of benefits from your prior group health plan, and state law permits such arrangements, your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Evidence of Coverage* shall be considered the secondary plan (paying any excess covered expenses), up to 100% of total covered expenses.

Late Enrollment Rule

Health Net's late enrollment rule requires that if an individual does not enroll within the time limit of becoming eligible for this Group coverage, they must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in "Employee" provision above.) For time limits for enrolling individuals who become eligible as a Dependent outside the Open Enrollment Period, see "Newly Acquired Dependents" provision above. See also "Exceptions to Late Enrollment Rule" below.

You may have decided not to enroll upon first becoming eligible. At that time, your employer should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

If you later change your mind and decide to enroll, Health Net can impose its late enrollment rule. This means that individuals identified on the form you signed will not be allowed to enroll before the next Open Enrollment Period. However, there are exceptions to this rule.

Exceptions to Late Enrollment Rule

If any of the circumstances below are true, the late enrollment rule will not apply to you.

1. **You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced**
   If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you if:
   - You never received from your employer or signed, a form explaining the consequences of your decision; or
   - The signed form exists, but cannot be produced as evidence of your informed decision.
2. **You or Your Dependents Did Not Enroll Because of Other Coverage and Later the Other Coverage Is Lost**
   If you or your Dependents declined coverage in this Plan and you stated on the form that the reason you or your Dependents were not enrolling was because of coverage through another group health plan and coverage is or will be lost for any of the following reasons, the late enrollment rule will not apply to you or your Dependents.
   - Loss of coverage in a plan with minimum essential coverage (except for either failure to pay premium contributions or a "for cause" termination such as fraud or misrepresentation of an important fact).
   - Loss of coverage because of termination of employment or reduction in the number of hours of employment.
   - Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area.
   - Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service area, and no other benefit package is available to the individual.
   - The other plan is terminated and not replaced with other group coverage.
   - The other employer stops making contributions toward employee's or Dependent's coverage.

- When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual.
- The other subscriber or employee dies.
- The Subscriber and spouse are divorced or legally separated and this causes loss of the other group coverage.
- Loss of coverage because of cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the Plan).
- The other coverage was federal COBRA or California COBRA, and the period of coverage ends.

3. **You are Determined Ineligible or Lose Eligibility from a Medi-Cal Plan**
   If you and/or your Dependents apply for coverage with Medi-Cal during the annual Open Enrollment Period and are determined ineligible for such coverage after open enrollment has ended or if you become ineligible and lose coverage under Medi-Cal, you and/or your Dependent(s) will be eligible to enroll in this Plan upon submitting a completed application form within 60 days of losing such coverage. If you and/or your Dependent(s) wait longer than 60 days to enroll, you and/or your Dependent(s) may not enroll until the next Open Enrollment Period.
4. **Multiple Health Plans**
   If you are enrolled as a dependent in a health plan (not Health Net), and the Subscriber, during open enrollment, chooses a different plan (such as moving from an HMO plan to a fee-for-service plan) and you do not wish to continue to be covered by it, you will not be considered a late enrollee should you decide to enroll in this Plan.
5. **Court Orders**
   If a court orders the Subscriber to provide coverage for a spouse (a current spouse, not a former spouse) or orders the Subscriber or enrolled spouse to provide coverage for a minor child through Health Net, that spouse or child will not be treated as a late enrollee.
6. **Other Special Enrollment Triggering Events**

   - An employee or their Dependent gains access to new health plans as a result of a permanent move.
   - An employee or their Dependent loses eligibility for coverage under Medi-Cal.
   - An enrollee or their Dependent's prior plan substantially violated a material provision of the health coverage contract.
   - An employee or enrollee or their Dependent was a member of the reserve forces of the United States military or a member of the California National Guard returning from active duty.
   - An employee is a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
   - An employee or their Dependent was 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. Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;

e. Care of a newborn between birth and 36 months; or

f. 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.

- An employee or their Dependent apply for coverage through Covered California during the annual Covered California Open Enrollment Period or due to a qualifying event and are assessed by Covered California as potentially eligible for Medi-Cal, and are determined ineligible for such coverage either after the Group open enrollment has ended or more than 60 days after the qualifying event.
- An employee or their Dependent apply for coverage with Medi-Cal during the annual Covered California Open Enrollment Period and are determined ineligible for such coverage after the Group open enrollment has ended.
- An employee or their Dependent demonstrates to the Department of Managed Health Care that they did not enroll in a health plan during the immediately preceding enrollment period available to the individual because they were misinformed that they were covered under minimum essential coverage.

If the exceptions in 2, 3 or 4 above apply, you must enroll within 60 days of the loss of coverage. If you wait longer than 60 days to enroll, you will be a late enrollee and you may not enroll until the next Open Enrollment Period. A court ordered Dependent may be added without any regard to open enrollment restrictions.

Special Enrollment Rule for Newly Acquired Dependents

If an employee gains new Dependents due to childbirth, adoption, marriage, or registration of domestic partnership the following rules apply.

If the Employee Is Enrolled in this Plan

If you are covered by this Plan as a Subscriber, you can enroll your new Dependent if you request enrollment within 60 days after childbirth, marriage, registration of domestic partnership, adoption or placement for adoption. In addition, a court ordered Dependent may be added without any regard to open enrollment restrictions.

More information about enrolling new Dependents and their Effective Date of coverage is available above under the heading "How to Enroll for Coverage" and the subheading "Newly Acquired Dependents."

If the Employee Declined Enrollment in this Plan

If you previously declined enrollment in this Plan because of other group coverage, and you gain a new Dependent due to childbirth, marriage, registration of domestic partnership, adoption, placement for

adoption, you can enroll yourself and the Dependent within 60 days of birth, marriage, registration of domestic partnership, adoption or placement for adoption.

If you gain a new Dependent due to a court order and you did not previously enroll in this Plan, you may enroll yourself and your court ordered Dependent(s) without any regard to open enrollment restrictions.

In addition, any other Family Members who are eligible for coverage may enroll at the same time as you and the new Dependent. You no longer have to wait for the next Open Enrollment Period, and whether or not you are covered by another group plan has no effect on this right.

If you do not enroll yourself, the new Dependent and any other Family Members within 60 days of acquiring the new Dependent, you will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for you and all Family Members who enroll within 60 days of childbirth, marriage, registration of domestic partnership, adoption or placement for adoption will be the same as for the new Dependent.

- In the case of childbirth, the Effective Date will be the moment of birth.
- For marriage or registration of domestic partnership, the Effective Date will be on the first day of the month following the date the application for coverage is received.
- Regarding adoption, the Effective Date for the adopted child or a child who is being adopted will be the date of adoption or the date of placement for adoption, as requested by the adoptive parent.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

  Note(s):

  When you (the employee) are not enrolled in this Plan, and you wish to have coverage for a newborn or adopted child who is ill, please contact your employer as soon as possible and ask that you (the employee) and the newborn or adopted child be enrolled. An employee must be enrolled in order for their eligible Dependent to be enrolled.

  While you have 60 days within which to enroll the child, until you and your child are formally enrolled and recorded as Members in our computer system, we cannot verify coverage to any inquiring medical provider.

Special Reinstatement Rule for Reservists Returning from Active Duty

Reservists ordered to active duty on or after January 1, 2007, who were covered under this Plan at the time they were ordered to active duty and their eligible Dependents will be reinstated without waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty pursuant to Public Law 107-243 or pursuant to Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

Transferring to Another Contracting Physician Group

As stated in "Selecting a Contracting Physician Group" portion of the "Introduction to Health Net" section, each person must select a contracting Physician Group close enough to their residence or place of work to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID card if you have questions involving reasonable access to care.

Any individual Member may change Physician Groups by transferring from one to another when:

- The Group's Open Enrollment Period occurs;
- The Member moves to a new address (notify Health Net within 30 days of the change);
- The Member's employment work-site changes (notify Health Net within 30 days of the change);
- Determined necessary by Health Net; or
- The Member exercises the once-a-month transfer option.

  Exception(s):

  Health Net will not permit a once-a-month transfer at the Member's option if the Member is confined to a Hospital. However, if you believe you should be allowed to transfer to another contracting Physician Group because of unusual or serious circumstances, and you would like Health Net to give special consideration to your needs, please contact the Customer Contact Center at the telephone number on your Health Net ID card for prompt review of your request.

Effective Date of Transfer

Once we receive your request for a transfer, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If your request for a transfer is not allowed because of a hospitalization and you still wish to transfer after the medical condition or treatment for it has ended, please call the Customer Contact Center to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following the date the treatment for the condition causing the delay ends.

For a newly eligible child who has been automatically assigned to a contracting Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible. (Automatic assignment takes place with *newborn* and *adopted* children and is described in "How to Enroll for Coverage" provision earlier in this section.)

When Coverage Ends

You must notify the Group of changes that will affect your eligibility. The Group will send the appropriate request to Health Net according to current procedures. Health Net is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

All Group Members

All Members of a Group become ineligible for coverage under this Plan at the same time if the Group Service Agreement (between the Group and Health Net) is terminated, including for termination due to nonpayment of subscription charges by the Group, as described below in the "Termination for Nonpayment of Subscription Charges" provision.

Termination for Nonpayment of Subscription Charges

If the Group fails to pay the required subscription charges when due, the Group Service Agreement could be canceled after a 30-day grace period.

When subscription charges are not paid by the due date, a Late Payment Notice is generated. The date of the Late Payment Notice is the first day of the 30-day grace period. The Notice will include the dollar amount due to Health Net, the last day of paid coverage, and the start and last day of the grace period after which coverage will be canceled if subscription charges are not paid. Coverage will continue during the grace period, but the Member is responsible for unpaid subscription charges and any required Copayments, coinsurance or Deductible amounts.

If Health Net does not receive payment of the delinquent subscription charges from your employer within the 30-day grace period, Health Net will mail a termination notice that will provide the following information: (a) that the Group Service Agreement has been canceled for nonpayment of Subscription Charges; (b) the specific date and time when coverage is terminated for the Subscribers and all Dependents; and (c) your right to submit a grievance.

If coverage through this Plan ends for reasons other than nonpayment of subscription charges, see the "Coverage Options Following Termination" section below for coverage options.

Termination for Loss of Eligibility

In addition to no longer residing in the service area, individual Members become ineligible on the date any of the following occurs:

- The Member no longer meets the eligibility requirements established by the Group and Health Net.

  This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

  1. The date established by the order.
  2. The date the order expired.

- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- The Subscriber's marriage or domestic partnership ends by divorce, annulment, or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled Dependents, who were related to the Subscriber only because of the marriage, will end.

When the Member ceases to reside in the Health Net Service Area, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred. However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area, does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care. Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by Health Net.

For any termination for loss of eligibility, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; (c) your right to submit a grievance; and (d) information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal. Once coverage is terminated, Health Net will send a termination notice which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice and (c) your right to submit a grievance.

The Subscriber and all their Family Members will become ineligible for coverage at the same time if the Subscriber loses eligibility for this Plan.

Termination for Cause

Health Net has the right to terminate your coverage from this Plan for good cause, as set forth below. Your coverage may be terminated with a 30-day written notice if you commit any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

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

We may also report criminal fraud and other illegal acts to the authorities for prosecution.

For any termination for cause, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; (c) your right to submit a grievance; and (d) information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal. Once coverage is terminated, Health Net will send a termination notice which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice and (c) your right to submit a grievance.

How to Appeal Your Termination

You have the right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the “Grievance Procedures” provision in the “General Provisions” section for information about how to appeal Health Net’s decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage under this Plan until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay the Deductible and Copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "Grievance Procedures" provision in the "General Provisions" section. If your complaint is decided in your favor, Health Net will reinstate your coverage back to the date of the termination.

Health Net will conduct a fair investigation of the facts before any termination for any of the above reasons is carried out. Your health status or requirements for Health Care Services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the director of the California Department of Managed Health Care.

Coverage Options Following Termination

If coverage through this Plan ends as a result of the Group's nonpayment of subscription charges, see "All Group Members" portion of "When Coverage Ends" in this section for coverage options following termination. If coverage through this Plan ends for reasons other than the Group's nonpayment of subscription charges, the terminated Member may be eligible for additional coverage.

- **COBRA Continuation Coverage:** Many groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible Dependents, even if they live outside California. Please check with your Group to determine if you and your covered Dependents are eligible.
- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage. This subject is detailed below in the section titled "Small Employer Cal-COBRA Continuation Coverage."
- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue Group coverage under this *Evidence of Coverage* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

  Health Net Will Offer Cal-COBRA to Members: Health Net will send Members whose federal COBRA coverage is ending information on Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose Cal-COBRA Continuation Coverage. This information will be sent by U.S. mail with the notice of pending termination of federal COBRA.

  Choosing Cal-COBRA: If an eligible Member wishes to choose Cal-COBRA Continuation Coverage, they must deliver the completed enrollment form (described immediately above) to

Health Net by first class mail, personal delivery, express mail, or private courier company. The address appears on the back cover of this *Evidence of Coverage*.

The Member must deliver the enrollment form to Health Net within 60 days of the later of (1) the Member's termination date for COBRA coverage or (2) the date they were sent a notice from Health Net that they may qualify for Cal-COBRA Continuation.

Payment for Cal-COBRA: The Member must pay Health Net 110% of the applicable Group rate charged for employees and their Dependents.

The Member must submit the first payment within 45 days of delivering the completed enrollment form to Health Net in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Member's first payment must be delivered to Health Net by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to Health Net, the Member's Cal-COBRA election is not effective, and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Member will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), Health Net will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Member fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by Health Net. If the Member makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Member by Health Net within 20 business days.

Employer Replaces Previous Plan: There are two ways the Member may be eligible for Cal-COBRA Continuation Coverage if the employer replaces the previous plan:

1. If the Member had chosen Cal-COBRA Continuation Coverage through a previous plan provided by their current employer and replaced by this Plan because the previous policy was terminated; or
2. If the Member selects this Plan at the time of the employer's open enrollment.

The Member may choose to continue to be covered by this Plan for the balance of the period that they could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new Plan, the Member must request enrollment and pay the required premium within 30 days of receiving notice of the termination of the prior plan. If the Member fails to request enrollment and pay the premium within the 30-day period, Cal-COBRA continuation coverage will terminate.

Employer Replaces this Plan: If the agreement between Health Net and the employer terminates, coverage with Health Net will end. However, if the employer obtains coverage from another insurer or HMO, the Member may choose to continue to be covered by that new plan for the balance of the period that they could have continued to be covered by the Health Net Plan.

When Does Cal-COBRA Continuation Coverage End? When a Qualified Beneficiary has chosen Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

1. You have been covered for 36 months from your original COBRA effective date (under this or any other plan).*

2. The Member becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Member moves outside the Health Net Service Area.
4. The Member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
5. The Group's Agreement with Health Net terminates. (See "Employer Replaces this Plan.")
6. The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

If the Member becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this Plan will continue. Coordination of benefits will apply, and Cal-COBRA plan will be the primary plan.

* The COBRA effective date is the date the Member first became covered under COBRA continuation coverage.

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

Small Employer Cal-COBRA Continuation Coverage

If a Subscriber or Family Member is about to lose coverage through this Plan for reasons other than the Group's nonpayment of subscription charges, and is interested in choosing continuation coverage, the Subscriber or Family Member needs to ask the employer whether the employer is subject to federal COBRA law. If the employer is subject to federal COBRA law, the employer will be the primary source of information about continuation coverage. If the employer is a Small Employer as defined below, contact the Customer Contact Center at the telephone number on your Health Net ID card.

Definitions

Small Employer Cal-COBRA Continuation Coverage means extended coverage by this Plan that is chosen by the Qualified Beneficiary following loss of coverage due to a Qualifying Event, but only if the employer is a Small Employer.

However, if this Plan has been terminated by Health Net or the employer and replaced by the employer, the continuation coverage is provided by the group health plan that is currently offered by the employer.

Also, if, during Small Employer Cal-COBRA Continuation Coverage, the Member chooses other coverage during the employer's Open Enrollment Period, continuation coverage is provided by that plan.

Qualified Beneficiary means anyone who, on the date of a Qualifying Event, is or was validly enrolled in this Plan or another group health plan sponsored by the employee's current employer.

Qualifying Event means any of the following events that, except for the choosing of Small Employer Cal-COBRA Continuation Coverage through this Plan, would result in loss of coverage for one or all enrolled Members:

- Termination of employment for reasons other than gross misconduct.*
- Reduction in hours worked.*
- Death of the employee or Subscriber. (36 months of coverage is available.)
- Divorce or legal separation of the enrolled employee from their enrolled spouse. (36 months of coverage is available.)
- A Dependent child ceases to be a Dependent child according to the eligibility rules of the Plan. (36 months of coverage is available.)
- A Family Member ceases to be eligible when the employee or Subscriber becomes entitled to Medicare coverage (enrolls in Medicare). (36 months of coverage is available.)

* The COBRA effective date is the date the Member first became covered under COBRA continuation coverage.

Small Employer means an employer that meets the definition of Small Employer as described in Section 1357.500 of the California Health and Safety Code or Section 1075 of the California Insurance Code. For Small Employer Cal-COBRA Continuation, the following must also be true of the employer:

- Employed fewer than 20 employees who were eligible to enroll in the company's health Plan on at least 50% of its working days during the preceding Calendar Year;
- Has contracting for health care coverage through a group benefit plan offered by a Health Care Service plan or a disability insurer; and
- Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C., Section 1161 et seq. (these describe federal COBRA).

Who Is Eligible for Small Employer Cal-COBRA Continuation Coverage?

Qualifying Event: If the Member is validly enrolled through this Plan, and they experience a Qualifying Event (as described above), and as a result of that event loses coverage through this Plan, that Member has the right to choose to continue to be covered by this Plan.

Employer Replaces Previous Plan: There are two ways the Member may be eligible for Small Employer Cal-COBRA Continuation Coverage if the employer replaces the previous plan:

- If the Member had chosen Small Employer Cal-COBRA Continuation Coverage through a previous Plan provided by their current employer and replaced by this Plan because the previous policy was terminated, or
- If the Member selects this Plan at the time of the Group's open enrollment.

The Member may choose to continue to be covered by this Plan for the balance of the period that they could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new Plan, the Member must request enrollment and pay the required premium within 30 days of receiving notice of the termination of the prior plan. If the Member fails to request enrollment and pay the premium within the 30-day period, Cal-COBRA continuation coverage will terminate.

Group Replaces This Plan: If the agreement between Health Net and the Group terminates, coverage with Health Net will end. However, if the Group obtains coverage from another insurer or HMO, the Member may choose to continue to be covered by that new plan for the balance of the period that they could have continued to be covered by the Health Net Plan.

Newborns and Adoptions During Small Employer Cal-COBRA Continuation Coverage: If a child is born to or placed for adoption with the former employee, the child shall have the status of Qualified Beneficiary. This means the child will have the same rights as all other Qualified Beneficiaries.

These newborns and adopted children are covered from the moment of birth or placement with the former employee for adoption, but the Member must formally enroll the child within 30 days of birth or placement in order for coverage to continue beyond 30 days. To do this, contact Health Net to request an enrollment form. Health Net must receive the enrollment form within 30 days of birth or placement, or coverage will not continue beyond 30 days.

Who May Choose Small Employer Cal-COBRA Continuation Coverage?

If the Subscriber experiences a Qualifying Event, they may choose Small Employer Cal-COBRA for themself alone, or for any one or all of the other Family Members who are enrolled at the time of the Qualifying Event. In addition, any individual who is enrolled at that time may choose Small Employer Cal-COBRA for themself alone. In other words, the Subscriber does not have to be among the persons who choose Small Employer Cal-COBRA Continuation Coverage. Further, a Subscriber may choose coverage for one or more minor children without an adult being included.

Who May Not Choose Small Employer Cal-COBRA Continuation Coverage?

Individuals may not choose Small Employer Cal-COBRA if the individual:

1. Is enrolled in Medicare.
2. Is covered by another group health plan that does not contain a pre-existing condition limitation that prevents the individual from receiving the full benefits of such plan.
3. If the individual is covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, the individual may choose Small Employer Cal-COBRA Continuation Coverage. Coordination of benefits will apply, and this Small Employer Cal-COBRA Plan will be the primary plan.
4. Is covered or could become covered by any federal laws regarding continuation of group health plan coverage.
5. Fails to notify Health Net of a Qualifying Event according to the requirements described below under “Notify Health Net of Small Employer Cal-COBRA Qualifying Event.”
6. Fails to submit the initial premium payment in the correct amount as described below under “Payment for Small Employer Cal-COBRA.”

Notify Health Net of Small Employer Cal-COBRA Qualifying Event

If the Member loses coverage through this Plan due to a Qualifying Event, and wishes to choose Small Employer Cal-COBRA Continuation Coverage, they must notify Health Net in writing within 60 days of the Qualifying Event. The Member must deliver the notice to Health Net by first class mail, personal delivery, express mail or private courier company to the address that appears on the ID card and on the back cover of this *Evidence of Coverage*.

If the Member fails to notify Health Net of a Qualifying Event within 60 days of the event, that Member will be disqualified from receiving Small Employer Cal-COBRA Continuation Coverage.

Health Net Will Offer Small Employer Cal-COBRA to Members

If a Member notifies Health Net in writing within 60 days of a Qualifying Event, Health Net will send that Member by U.S. mail information about their Small Employer Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms and instructions to formally choose Small Employer Cal-COBRA Continuation Coverage.

Choosing Small Employer Cal-COBRA

If a Member wishes to formally choose Small Employer Cal-COBRA Continuation Coverage, they must deliver the completed enrollment form (described immediately above) to Health Net by first class mail, personal delivery, express mail or private courier company. The address appears on the ID card and on the back cover of this *Evidence of Coverage*.

The Member must deliver the enrollment form to Health Net within 60 days of the later of (1) the Qualifying Event or (2) the date they received a notice from Health Net that they have the right to continue Small Employer Cal-COBRA Continuation Coverage or (3) the date that coverage through the employer Plan terminated.

Payment for Small Employer Cal-COBRA

The Member must pay Health Net 110% of the applicable group rate charged for employees and their Dependents.

The Member must submit the first payment within 45 days of delivering the completed enrollment form to Health Net in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Small Employer Cal-COBRA Continuation Coverage. The Member's first payment must be delivered to Health Net by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to Health Net, the Member's Cal-COBRA election is not effective, and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Member will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), Health Net will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Member fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by Health Net. If the Member makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Member by Health Net within 20 business days.

When Does Small Employer Cal-COBRA Continuation Coverage End?

When a Qualified Beneficiary has chosen Small Employer Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

- 36 months from the date coverage would ordinarily have ended due to termination of employment for reasons other than gross misconduct.*

- 36 months from the date coverage would ordinarily have ended due to reduction in hours worked.*
- 36 months from the date coverage would ordinarily have ended due to*:
  1. Death of the covered employee or Subscriber.
  2. Divorce or separation of the covered employee or Subscriber from their spouse.
  3. Loss of Dependent status by a covered Dependent child.
  4. The Subscriber becomes entitled to Medicare, that is, enrolls in the Medicare program.
- The Member becomes or could become covered, in accordance with any federal laws regarding continuation of group health plan coverage.
- The Member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Small Employer Cal-COBRA."
- The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

If the Member becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this Plan will continue. Coordination of benefits will apply, and this Small Employer Cal-COBRA Plan will be the primary plan.

* The COBRA effective date is the date the Member first became covered under COBRA continuation coverage.

Under no circumstances may a Qualified Beneficiary be covered by Small Employer Cal-COBRA Continuation Coverage for more than 36 months.

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if you lose your Health Net coverage because the Group Service Agreement is discontinued, and you are ***totally disabled*** at that time. When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in the "Schedule of Benefits and Copayments" section, will continue to apply.

Benefits will only be extended for the condition that caused you to become totally disabled. Benefits will not be extended for other medical conditions.

Benefits will not be extended if coverage was terminated for cause as stated in "Individual Members - Termination for Cause" provision of this "Eligibility, Enrollment and Termination" section.

"**Totally disabled**" has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which they are or will become qualified by reason of education, training or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of their age and family status.

How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated, and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

If benefits are extended because of total disability, provide Health Net with proof of total disability at least once every 90 days during the extension. The Member must ensure that Health Net receives this proof before the end of each 90-day period.

When the Extension Ends

The Extension of Benefits will end on the *earliest* of the following dates:

1. On the date the Member is no longer totally disabled;
2. On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
3. On the date that available benefits are exhausted; or
4. On the last day of the 12-month period following the date the extension began.

COVERED SERVICES AND SUPPLIES

You are entitled to receive Medically Necessary services and supplies described below when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not in itself, make it Medically Necessary or make it a covered service. All covered services and supplies, except for Emergency Care and Urgently Needed Care, for Subscribers and their eligible Dependents must be performed by the Physician Group or authorized by them to be performed by another provider.

Any covered service or supply may require a Copayment, be subject to a Deductible, or have a benefit maximum. Please refer to the "Schedule of Benefits and Copayments" section for details.

Certain limitations may apply. Be sure you read the section entitled the "Exclusions and Limitations" section before obtaining care.

Medical Services and Supplies

Office Visits

Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals when you are referred by your Primary Care Physician.

CVS MinuteClinic Services

CVS MinuteClinic visits for Preventive Care Services and for the diagnosis and evaluation of minor illnesses or injuries are covered as shown in the "Schedule of Benefits and Copayments" section.

Preventive Care Services that may be obtained at a CVS MinuteClinic include services such as:

- Vaccinations;
- Health condition monitoring for asthma, diabetes, high blood pressure or high cholesterol; and
- Wellness and preventive services including, but not limited to, asthma, cholesterol, diabetes and blood pressure screenings, pregnancy testing and weight evaluations.

In addition, the CVS MinuteClinic also provides non-Preventive Care Services, such as the evaluation and diagnosis of:

- Minor illnesses, including, flu, allergy or sinus symptoms, body aches, and motion sickness prevention;
- Minor injuries, including blisters, burns, sprains (foot, ankle, or knee), and wounds and abrasions; and
- Minor skin conditions, such as, minor infections, rashes, or sunburns, wart treatment, or poison ivy.

You do not need Prior Authorization or a referral from your Primary Care Physician or contracting Physician Group in order to obtain access to CVS MinuteClinic services. However, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations.

You will receive a written visit summary at the conclusion of each CVS MinuteClinic visit. With your permission, summaries of your CVS MinuteClinic visit, regardless of visit type, are sent to your Primary

Care Physician. If you require a nonemergent referral to a Specialist, you will be referred back to your Primary Care Physician for coordination of such care.

Members traveling in another state which has a CVS Pharmacy with a MinuteClinic can access MinuteClinic covered services under this Plan at that MinuteClinic under the terms of this *Evidence of Coverage*.

If a Prescription Drug is required as part of your treatment, the CVS MinuteClinic clinician will prescribe the Prescription Drug. You will not need to return to your Primary Care Physician for a Prescription Drug Order.

Certain limitations or exclusions may apply. CVS MinuteClinics may offer some services that are not covered by this Plan. Please refer to the "General Exclusions and Limitations" portion of the "Exclusions and Limitations" section for more information. For additional information about CVS MinuteClinics, please contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card.

Preventive Care Services

The coverage described below shall be consistent with the requirements of the Affordable Care Act (ACA).

Preventive Care Services are covered for children and adults, as directed by your Physician, based on the guidelines from the following resources:

- U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations (https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (http://www.cdc.gov/vaccines/schedules/index.html)
- Guidelines for infants, children and adolescents as supported by the Health Resources and Services Administration (HRSA). These recommendations are referred to as Bright Futures. (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Guidelines for women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services is available through www.healthcare.gov/preventive-care-benefits/. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screenings
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) recommended cancer screenings, including: cervical cancer screening, (including human papillomavirus (HPV) screening), and screening for prostate cancer (including prostate-specific antigen testing and digital rectal examinations), lung cancer, and colorectal cancer screening (e.g., colonoscopies)

Breast cancer screening (mammograms, including three-dimensional (3D) mammography, also known as digital breast tomosynthesis). Additional breast imaging (e.g., MRI, ultrasound) and pathology evaluation is covered if additional imaging is indicated to complete the screening process

- Human immunodeficiency virus (HIV) testing and screening
- Pre-Exposure Prophylaxis (PrEP) medications for the prevention of HIV infection, including related medical services - baseline and follow-up testing and ongoing monitoring (e.g., HIV testing, kidney function testing, serologic testing for hepatitis B and C virus, testing for other sexually transmitted infections, pregnancy testing when appropriate and adherence counseling)
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases, HIV, and reducing alcohol use
- Routine immunizations to prevent diseases and infections, as recommended by the ACIP (e.g., chickenpox, measles, polio, meningitis, mumps, flu, pneumonia, shingles, HPV)
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Anxiety screening for children and adolescents
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes (diabetes in pregnancy); sexually transmitted infection counseling; human immunodeficiency virus (HIV) counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies and counseling; screening for anxiety; screening and counseling for intimate partner and domestic violence.

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the Member. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by your Physician. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. You can find out how to obtain a breast pump by calling the Customer Contact Center at the phone number on your Health Net ID card or contacting us at www.healthnet.com.

Preventive Care Services are covered as shown in the “Schedule of Benefits and Copayments” section.

COVID-19 Outpatient Services

COVID-19 diagnostic and screening testing, therapeutics, and vaccinations are:

- Covered in full when provided by a Participating Pharmacy or provider within the HMO Network; or
- Covered at a 50% Member cost share when provided by a Nonparticipating Pharmacy or provider. You may be required to pay out-of-pocket and submit a medical claim for reimbursement. See “Notice of Claim” under the “Miscellaneous Provisions” section.

The cost shares above apply to these listed services only.

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment are covered as shown in the "Schedule of Benefits and Copayments" section. Preventive vision and hearing screening are covered as Preventive Care Services. See the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" for information regarding vision examinations for children under 19 years of age.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

If you are a female Member, you may obtain OB/GYN Physician services without first contacting your Primary Care Physician.

If you need OB/GYN Preventive Care Services, are pregnant or have a gynecology ailment, you may go directly to an OB/GYN Specialist or a Physician who provides such services in your Physician Group.

If such services are not available in your Physician Group, you may go to one of the contracting Physician Group's referral Physicians who provides OB/GYN services. (Each contracting Physician Group can identify its referral Physicians.)

The OB/GYN Physician will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for Follow-Up Care.

Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits and Copayments" section. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits and Copayments" section.

The coverage described above meets the requirements of the Affordable Care Act (ACA), which states:

You do not need Prior Authorization or a referral from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our website at www.healthnet.com or contact the Customer Contact Center at the phone number on your Health Net ID card.

Self-Referral for Reproductive and Sexual Health Care Services

You may obtain reproductive and sexual health care Physician services without first contacting your Primary Care Physician or securing a referral from your Primary Care Physician. Reproductive and sexual Health Care Services include but are not limited to: pregnancy services, including contraceptives and treatment; diagnosis and treatment of sexually transmitted disease (STD); medical care due to rape or sexual assault, including collection of medical evidence; and HIV testing.

If you need reproductive or sexual Health Care Services, you may go directly to a reproductive and sexual health care Specialist or a Physician who provides such services in your Physician Group.

If such services are not available in your Physician Group, you may go to one of the contracting Physician Group's referral Physicians who provides reproductive and sexual Health Care Services. (Each contracting Physician Group can identify its referral Physicians.)

The reproductive and sexual health care Physician will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for Follow-Up Care.

Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits and Copayments" section. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits and Copayments" section.

Treatment Related to Rape or Sexual Assault

This Plan provides covered services and supplies for a Member who is treated following a rape or sexual assault. These services include Emergency Care, Follow-Up Care, medical care, behavioral health care, and outpatient Prescription Drugs. These services will be covered in full.

These benefits do not require the Member to file a police report, charges to be brought against an assailant, or an assailant to be convicted of rape or sexual assault in order to be covered.

Immunizations and Injections

This Plan covers immunizations and injections (including infusion therapy when administered by a health care professional in the office setting), professional services to inject the medications and the medications that are injected. This includes allergy serum. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits and Copayments" section.

In addition, injectable medications approved by the FDA to be administered by a health care professional in the office setting are covered.

You will be charged the appropriate Copayment as shown in the "Schedule of Benefits and Copayments" section.

Surgical Services

Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered.

Surgically Implanted Drugs

Surgically implanted drugs are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

Gender Affirming Surgery

Medically Necessary gender affirming services, including, but not limited to, Mental Health evaluation and treatment, pre-surgical and post-surgical hormone therapy, fertility preservation, speech therapy, and surgical services (such as, hysterectomy, ovariectomy, and orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery), for the treatment of gender dysphoria or gender identity disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

Laboratory and Diagnostic Imaging (including X-ray) Services

Laboratory and diagnostic imaging (including x-ray) services and materials are covered as Medically Necessary.

Home Visit

Visits by a Member Physician to a Member's home are covered at the Physician's discretion in accordance with the rules and criteria set by Health Net and if the Physician concludes that the visit is medically and otherwise reasonably indicated.

Rehabilitation Therapy

Rehabilitation therapy services (physical, speech and occupational therapy) are covered when Medically Necessary, except as stated in the "Exclusions and Limitations" section.

Habilitative Services

Coverage for habilitative services and/or therapy is limited to Health Care Services and devices that help a person keep, learn, or improve skills and functioning for daily living, when provided by a Member Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical conditions and Mental Health and Substance Use Disorders or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism, subject to any required authorization from Health Net or your Physician Group. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group and address the skills and abilities needed for functioning in interaction with an individual's environment.

Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under this *Evidence of Coverage*.

Cardiac Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of heart disease is covered when Medically Necessary.

Pulmonary Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary.

Clinical Trials

Routine patient care costs for items and services furnished in connection with participating in an approved clinical trial are covered when Medically Necessary, authorized by Health Net and either the Member's treating Physician has recommended participation in the trial, or the Member has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by nonparticipating providers are covered only when the protocol for the trial is not available through a participating provider within California. Services rendered as part of a clinical trial may be provided by a nonparticipating or participating provider subject to the reimbursement guidelines as specified in the law.

The following definitions apply to the terms mentioned in the above provision only.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved or funded through in-kind donations by one of the following:

- The National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the federal Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs; or
- A cooperative group or center of any of the entities described above; or
- A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    1. The United States Department of Veterans Affairs.
    2. The United States Department of Defense.
    3. The United States Department of Energy; or
- The FDA as an Investigational new drug application.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Routine patient care costs" are the costs associated with the requirements of Health Net, including drugs, items, devices and services that would normally be covered under this *Evidence of Coverage*, if they were not provided in connection with a clinical trials program.

Please refer to the "Services and Supplies" portion of the "Exclusions and Limitations" section for more information.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered.

Prenatal diagnostic procedures include services provided by the California Prenatal Screening Program administered by the California Department of Public Health and are covered at no cost to the Members.

The California Prenatal Screening Program is a statewide program offered by prenatal care providers to all pregnant individuals in California. Prenatal screening uses a pregnant individual's blood samples to screen for certain birth defects in their fetus. Prenatal screenings must be performed at or through a PNS-contracted lab. Individuals with a fetus found to have an increased chance of one of those birth

defects are offered genetic counseling and other follow-up services through state-contracted Prenatal Diagnosis Centers.

Please refer to the "Schedule of Benefits and Copayments" section for Copayment requirements.

Termination of pregnancy and related services, including initial consultation, diagnostic services and follow up care, are covered at no cost to the Member. Travel allowances for Members outside California may be available; call the Customer Contact Center at the telephone number on your Health Net ID card for additional information.

Health Net offers a doula program for Members who are pregnant or were pregnant in the past year. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, including support for miscarriage, stillbirth, and termination of pregnancy. For more information, you can call the Customer Contact Center telephone number listed on your Health Net ID card or visit our website at www.healthnet.com.

Coverage for pregnancy includes at least one maternal mental health screening during pregnancy and another within the first six weeks postpartum. Additional screenings will be provided if your provider determines they are Medically Necessary.

As an alternative to a Hospital setting, birthing center services are covered when authorized by your Physician Group. A birthing center is a homelike facility accredited by the Commission for Accreditation of Birth Centers (CABC) that is equipped, staffed and operated to provide maternity-related care, including prenatal, labor, delivery and postpartum care. Services provided by other than a CABC-accredited designated center will not be covered.

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service are covered as Preventive Care Services.

When you give birth to a child in a Hospital, you are entitled to coverage of at least 48 hours of care following a vaginal delivery or at least 96 hours following a cesarean section delivery.

Your Physician will not be required to obtain authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital will require authorization. Also, the performance of elective cesarean sections must be authorized.

You may be discharged earlier only if you and your Physician agree to it.

If you are discharged earlier, your Physician may decide, at their discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care. Your Physician will not be required to obtain authorization for this visit.

The coverage described above meets requirements for Hospital length of stay under the ***Newborns' and Mothers' Health Protection Act of 1996****, which states:*

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as

applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Donor human milk is an alternative to breastfeeding or formula for infants and is of particular benefit to pre-term infants. Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered. See “Prostheses” in the “Schedule of Benefits and Copayments” section for Copayment or Coinsurance requirements.

Family Planning

This Plan covers counseling and planning for contraception, fitting examination for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an Intrauterine Device (IUD). Sterilization of males and females is covered as described in the “Family Planning” portion of “Schedule of Benefits and Copayments.” Sterilization of females and contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include Intrauterine Devices (IUDs), injectable and implantable contraceptives. Contraceptives that are covered under the pharmacy benefit are described in the “Prescription Drugs” portion of this “Covered Services and Supplies” section of this *Evidence of Coverage*.

Fertility Preservation

This Plan also covers Medically Necessary services and supplies for standard fertility preservation treatments for iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Standard fertility preservation services are procedures consistent with the established medical treatment practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

This benefit is subject to the applicable Copayments shown in the “Schedule of Benefits and Copayments” section as would be required for covered services to treat any illness or condition under this Plan.

Medical Social Services

Hospital discharge planning and social service counseling are covered. In some instances, a medical social service worker may refer you to noncontracting providers for additional services. These services are covered only when authorized by your Physician Group and not otherwise excluded under this Plan.

Patient Education

Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered. Your Physician Group will coordinate access to these services. Health Net will pay for a diabetes instruction program supervised by a licensed or registered health care professional. A diabetes instruction program is a program designed to teach you (the diabetic) and your covered Dependent about the disease process, medical nutrition therapy and the daily management of diabetic therapy.

Home Health Care Services

The services of a Home Health Care Agency in the Member's home are covered when provided by a registered nurse or licensed vocational nurse and/or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services must be ordered by your Physician, approved by your Physician Group or health Plan and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Member is homebound because of illness or injury (this means that the Member is normally unable to leave home unassisted, and, when the Member does leave home, it must be to obtain medical care, or for short, infrequent nonmedical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Member's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See the "Definitions" section.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when appropriate for the Member's illness, injury or condition and will be covered for the number of days necessary to treat the illness, injury or condition.

Infusion therapy includes: Total Parenteral Nutrition (TPN) (nutrition delivered through the vein); injected or intravenous antibiotic therapy; chemotherapy; injected or intravenous Pain management; intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein); aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist); and tocolytic therapy to stop premature labor.

Covered services include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable Prescription Drugs or other substances which are approved by the California Department of Public Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substances are covered.

All services must be billed and performed by a provider licensed by the state. Only a 30-day supply will be dispensed per delivery.

Infusion therapy benefits will not be covered in connection with the following:

- Infusion medication administered in an outpatient Hospital setting that can be administered in the home or a non-Hospital infusion suite setting;
- Non-Prescription Drugs or medications;
- Any drug labeled "Caution, limited by federal law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA-approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA-approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including, but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Ambulance Services

All air and ground ambulance and ambulance transport services provided as a result of a "**911**" emergency response system request for assistance will be covered when the criteria for Emergency Care, as defined in this *Evidence of Coverage*, have been met.

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, Health Net must still be contacted as soon as possible and we must authorize the services.

Nonemergency ambulance and psychiatric transport van services are covered if a Physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services.

Please refer to the "Ambulance Services" provision of the "Exclusions and Limitations" section for additional information.

Hospice Care

Hospice care is available for Members diagnosed as terminally ill by a Member Physician and the contracting Physician Group. To be considered terminally ill, a Member must have been given a medical prognosis of one year or less to live.

Hospice care includes Physician services, counseling, medications, other necessary services and supplies and homemaker services. The Member Physician will develop a plan of care for a Member who elects Hospice care.

In addition, up to five consecutive days of inpatient care for the Member may be authorized to provide relief for relatives or others caring for the Member.

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, standard curved handle or quad cane and supplies, dry pressure pad for a mattress, compression burn garments, IV pole, tracheostomy tube and supplies, enteral pump and supplies, bone stimulator, cervical traction (over door), phototherapy blankets for treatment of jaundice in newborns, bracing, supports, casts, nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Member.

Equipment and medical supplies required for home hemodialysis and home peritoneal dialysis are covered after you receive appropriate training at a dialysis facility approved by Health Net. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs.

Except for podiatric devices to prevent or treat diabetes-related complications as discussed below, Corrective Footwear (including specialized shoes, arch supports and inserts) is only covered when all of the following circumstances are met:

- The Corrective Footwear is Medically Necessary;
- The Corrective Footwear is custom made for the Member; and
- The Corrective Footwear is permanently attached to a Medically Necessary orthotic device that is also a covered benefit under this Plan.

Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered under the “Diabetic Equipment” benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health Net will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

In assessing Medical Necessity for Durable Medical Equipment (DME) coverage, Health Net applies nationally recognized DME coverage guidelines, such as those defined by InterQual (McKesson) and the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

We also cover up to two Medically Necessary contact Lenses per eye (including fitting and dispensing) in any 12-month period to treat conditions of aniridia (missing iris). An aniridia contact lens will not be

covered if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months.

For adults age 19 and older, special contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact Lenses for that eye during the same Calendar Year. For children through age 18, see "Pediatric Vision Services" portion of "Covered Services and Supplies" for coverage details.

Coverage for Durable Medical Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of the "Exclusions and Limitations" section. Please refer to the "Schedule of Benefits and Copayments" section for the applicable Copayment.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the "Preventive Care Services" provision in this "Covered Services and Supplies" section.

When applicable coverage includes fitting and adjustment of covered equipment or devices.

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*
- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin, including pen needles*
- Specific brands of insulin syringes*

* These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the "Prescription Drugs" portion of this section for additional information.

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding Eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunizations and Injections" portion of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" portion of this section for more information.

Bariatric (Weight Loss) Surgery

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 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. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon.

If you live 50 miles or more from the nearest Health Net Bariatric Surgery Performance Center, you are eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Member and for the prior approved bariatric weight loss surgery. All requests for travel expense reimbursement must be prior approved by Health Net.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Member) to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of three (3) trips (work-up visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Member not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Member) not to exceed $100 per day, up to four (4) days for the Member's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net.

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered if the transplant is authorized by Health Net and performed at a Health Net Transplant Performance Center.

Health Net has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Member Physician can provide you with information about our Transplant Performance Centers. You will be directed to a designated Health Net Transplant Performance Center at the time authorization is obtained.

Medically Necessary services, in connection with an organ, tissue or stem cell transplant are covered as follows:

- For the enrolled Member who receives the transplant; and
- For the donor (whether or not an enrolled Member). Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered.

For more information on organ donation coverage, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Evaluation of potential candidates is subject to Prior Authorization. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is Medically Necessary.

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donation, including how to elect to be an organ donor, please visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

Renal Dialysis

Renal dialysis services in your home service area are covered. Dialysis services for Members with End-Stage Renal Disease (ESRD) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of your home service area must be arranged and authorized by your Physician Group or Health Net in order to be performed by providers in your temporary location. We also cover inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided the Member receives appropriate training at a dialysis facility. Outpatient dialysis received out of the United States is not a covered service.

Prostheses

Internal and external prostheses required to replace a body part are covered, including fitting and adjustment of such prostheses. Examples are artificial legs, surgically implanted hip joints, prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect, devices to restore speaking after a laryngectomy and visual aids (excluding Eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

In addition, prostheses to restore symmetry after a Medically Necessary mastectomy (including lumpectomy) and prostheses to restore symmetry and treat complications, including lymphedema, are covered. Lymphedema wraps and garments are covered, as well as up to three brassieres in a 12-month period to hold a prosthesis.

In addition, enteral formula for Members who require tube feeding is covered in accordance with Medicare guidelines.

Health Net or the Member's Physician Group will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, Health Net or the Physician Group will determine which device or appliance will be covered. The device must be among those that the Food and Drug Administration has approved for general use.

Prostheses will be replaced when no longer functional. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to replace or repair an item.

Prostheses are covered as shown under "Medical Supplies" in the "Schedule of Benefits and Copayments" section.

Ostomy and Urological Supplies

Ostomy and urological supplies are covered under the "Prostheses" benefit as shown under "Medical Supplies" in the "Schedule of Benefits and Copayments" section and include the following:

- Adhesives - liquid, brush, tube, disc or pad
- Adhesive removers
- Belts - ostomy
- Belts - hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles - bedside and leg
- Dressing supplies
- Irrigation supplies
- Lubricants
- Miscellaneous supplies - urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches - urinary. drainable, ostomy
- Rings - ostomy rings
- Skin barriers
- Tape - all sizes, waterproof and nonwaterproof.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered.

Inpatient Hospital Confinement

Covered services include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary;
- Physician services;
- Specialized and critical care;
- General nursing care;
- Special duty nursing as Medically Necessary;
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy, and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services;
- Durable Medical Equipment and supplies;
- Medical social services;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products are covered; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Outpatient Hospital Services

Professional services, outpatient Hospital facility services and outpatient surgery performed in a Hospital or Outpatient Surgical Center are covered.

Professional services performed in the outpatient department of a Hospital (including, but not limited to, a visit to a Physician, rehabilitation therapy, including physical, occupational and speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, laboratory tests, x-ray, radiation therapy and chemotherapy) are subject to the same Copayment which is required when these services are performed at your Physician Group.

Copayments for surgery performed in a Hospital or Outpatient Surgical Center may be different than Copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Facility Services" in the "Schedule of Benefits and Copayments" section of this *Evidence of Coverage* for more information.

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery 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 only a minimal improvement in the appearance of the Member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of the "Exclusions and Limitations" section. Reconstructive surgery includes 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.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies (including lumpectomies) and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required. This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

*The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the **Women's Health and Cancer Rights Act of 1998**. In compliance with the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also "Prostheses" in this "Covered Services and Supplies" section for a description of coverage for prostheses.*

Skilled Nursing Facility

Care in a room of two or more is covered. Benefits for a private room are limited to the facility's most common charge for a two-bed room, unless a private room is Medically Necessary. Covered services at a Skilled Nursing Facility include the following services:

- Physician and nursing services;
- Room and board;
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accordance with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel;
- Durable Medical Equipment in accordance with our Durable Medical Equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment;

- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide;
- Medical social services;
- Blood, blood products, and their administration;
- Medical supplies;
- Physical, occupational, and speech therapy;
- Behavioral health treatment for pervasive developmental disorder or autism; and
- Respiratory therapy.

A Member does not have to have been hospitalized to be eligible for Skilled Nursing Facility care.

Benefits are limited to the number of days of care stated in the "Schedule of Benefits and Copayments" section.

Phenylketonuria (PKU)

Coverage for testing and treatment of Phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product for use at home that is prescribed by a Physician.

"Special food product" is a food product that is prescribed by a Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

To request an authorization for a second opinion, contact your Primary Care Physician or the Customer Contact Center at the telephone number on your Health Net ID card. Physicians at your Physician Group or Health Net will review your request in accordance with Health Net's procedures and timelines as stated in the second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments. You may obtain a copy of this policy from the Customer Contact Center.

All authorized second opinions must be provided by a Physician who has training and expertise in the illness, disease or condition associated with the request.

Telehealth Services

Covered services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as covered services delivered in-person. For supplemental services that may provide telehealth coverage for certain services at a lower cost, see the "Telehealth Consultations Through the Select Telehealth Services Provider" provision below. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

Telehealth Consultations Through the Select Telehealth Services Provider

Health Net contracts with certain Select Telehealth Services Providers to provide Telehealth Services for medical conditions and Mental Health and Substance Use Disorders. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card. Services from the Select Telehealth Services Provider are not intended to replace services from your Physician, but are a supplemental service that may provide telehealth coverage for certain services at a lower cost. You are not required to use the Health Net Select Telehealth Services Provider for your Telehealth Services.

Telehealth consultations through the Select Telehealth Services Provider are confidential consultations by telephone or secure online video. The Select Telehealth Services Provider provides primary care services and may be used when your Physician's office is closed or you need quick access to a Physician or Participating Mental Health Professional. You do not need to contact your Primary Care Physician prior to using telehealth consultation services through the Select Telehealth Services Provider.

Prescription Drug Orders received from the Select Telehealth Services Provider, Physician or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the "Prescription Drugs" portion of the "Schedule of Benefits and Copayments" section and the coverage and Prior Authorization requirements, exclusions and limitations shown in the "Prescription Drugs" portions of the "Covered Services and Supplies" and Exclusions and Limitations" sections.

These services are subject to the limitations described in the "Telehealth Consultations Through the Select Telehealth Services Provider" portion of the "Exclusions and Limitations" section.

Please refer to the definitions of "Select Telehealth Services Provider" and "Telehealth Services" in the "Definitions" section for more information.

Prescription Drugs

Please read the "Prescription Drugs" portion of the "Exclusions and Limitations" section.

Cost-sharing and any accrual of amounts from all Drug Coupons paid on your behalf for any Prescription Drugs obtained by you through the use of a Drug Discount, Coupon, or Copay Card provided by a Prescription Drug manufacturer will not apply toward your Plan Deductible or Out-of-Pocket Maximum.

Covered Drugs and Supplies

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "Exclusions and Limitations" section of this *Evidence of Coverage* to find out if a particular condition is not covered.

Tier 1 Drugs (Most Generic and Low-Cost Preferred Brand Name Drugs) and Tier 2 Drugs (Nonpreferred Generic Drugs and Preferred Brand Name Drugs, Certain Brand Name Drugs with a Generic Equivalent or Drugs Recommended by the Pharmacy and Therapeutics Committee Based on Drug Safety, Efficacy and Cost)

Tier 1 and Tier 2 Drugs listed in the Health Net Essential Drug List (also referred to as "the List") are covered, when dispensed by Participating Pharmacies and prescribed by a Physician from your selected Physician Group, an authorized referral Specialist or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net in order to be covered. The fact that a drug is listed in the Essential Drug List does not guarantee that your Physician will prescribe it for you for a particular medical condition.

Tier 3 Drugs

Tier 3 Drugs are Prescription Drugs that are nonpreferred Brand Name Drugs, drugs that generally have a preferred and often less costly therapeutic alternative at a lower Tier, drugs recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy and cost, drugs listed as Tier 3 Drugs in the Essential Drug List, drugs indicated as "NF," if approved, or drugs not listed in the Essential Drug List.

Some Tier 3 Drugs require Prior Authorization from Health Net in order to be covered.

Please refer to the "Essential Drug List" portion of this section for more details.

Tier 4 Drugs (Specialty Drugs)

Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply. These drugs may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly, or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes drugs that the FDA or drug manufacturer requires to be distributed through a specialty pharmacy, or have high cost as established by Covered California. Tier 4 Drugs (Specialty Drugs) are identified in the Essential Drug List with "SP." Refer to Health Net's Essential Drug List on

our website at www.healthnet.com for the Tier 4 Drugs (Specialty Drugs) listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card or visit our website at www.healthnet.com.

All Tier 4 Drugs (Specialty Drugs) require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 Drugs (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 Tier 4 Drugs (Specialty Drugs), which are subject to Prior Authorization and must be obtained through Health Net's contracted specialty pharmacy vendor. Your Primary Care Physician 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.

Generic Equivalents to Brand Name Drugs

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Brand Name Drugs that have generic equivalents will be dispensed when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, subject to the Copayment requirements described in the "Prescription Drugs" portion of the "Schedule of Benefits and Copayments" section.

Off-Label Drugs

A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
   A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
   B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Essential Drug List or Prior Authorization by Health Net has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
   A. The American Hospital Formulary Service Drug Information; OR
   B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
      i. The Elsevier Gold Standard's Clinical Pharmacology.
      ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
      iii. The Thomson Micromedex DrugDex; OR

C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening" means either or both of the following:

A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;

B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential Drug List. Diabetic supplies are also covered including, but not limited to, specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and testing strips, ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to "Medical Services and Supplies" portion of this section under "Diabetic Equipment," for additional information. Refer to the "Schedule of Benefits and Copayments" section for details about the supply amounts that are covered and the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Essential Drug List. Inhaler spacers and peak flow meters used for the management and treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section under "Durable Medical Equipment" for additional information.

Compounded Drugs

Compounded drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded drugs (that use FDA-approved drugs for an FDA-approved indication) are covered when at least one of the primary ingredients is on the Essential Drug List and when there is no similar commercially available product. Compounded drugs must be obtained from a Participating Pharmacy, and are subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section, for information about FDA-approved drugs for off-label use. Coverage for compounded drugs requires the Tier 3 Drug Copayment, must be obtained from a Participating Pharmacy, and is subject to Prior Authorization by the Plan and Medical Necessity.

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. These Prescription Drugs are covered for up to the number of doses or tablets specified in the "Essential Drug List." For information about Health Net's Essential Drug List, please call the Customer Contact Center at the telephone number on your ID card or visit our website at www.healthnet.com to view the Essential Drug List.

Preventive Drugs and Contraceptives

Preventive drugs, including smoking cessation drugs and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. Covered preventive drugs are over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs.

Drugs for the relief of nicotine withdrawal symptoms require a prescription from the treating Physician. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

Covered contraceptives are FDA-approved contraceptives that are either available over-the-counter or are available with a Prescription Drug Order. Contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal and emergency contraceptives and condoms. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Essential Drug List.

Over-the-counter preventive drugs that are covered under this Plan, except for over-the-counter contraceptives, require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs. Over-the-counter contraceptives that are covered under this Plan do not require a Prescription Drug Order but must be obtained from a Health Net Participating Pharmacy at the Prescription Drug counter.

Intrauterine Devices (IUDs), injectable and implantable contraceptives are covered as a medical benefit when administered by a Physician. Please refer to the "Medical Services and Supplies" portion of this section, under the headings "Preventive Care Services" and "Family Planning" for information regarding contraceptives covered under the medical benefit.

For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy. Emergency contraceptives required in conjunction with Emergency Care, as defined under the "Definitions" section, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Care as defined.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs that require a prescription in order to be dispensed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. The prescribing Physician must request and obtain Prior Authorization for coverage.

The Essential Drug List

What Is the Health Net Essential Drug List?

Health Net developed the Essential Drug List to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Health Net contracting Physicians 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 Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Essential Drug List identifies whether a generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the generic version exists, it will be dispensed instead of the brand name version.

You may call the Customer Contact Center at the telephone number on your Health Net ID card to find out if a particular drug is listed in the Essential Drug List. You may also request a copy of the current List and it will be mailed to you. The current List is also available on the Health Net website at www.healthnet.com. To obtain specific benefit and drug information, including your cost for a specific drug at your preferred pharmacy, please log into your secure Member portal or call the Customer Contact Center at the number on your Health Net ID card.

How Are Drugs Chosen for the Health Net Essential Drug List?

The List is created and maintained by the Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the List, the committee reviews medical and scientific publications, relevant utilization experience, state and federal requirements and Physician recommendations to assess the drug for its:

- Safety
- Effectiveness
- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed)
- Side effect profile
- Therapeutic outcome

This committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the List. The Essential Drug List is updated as new clinical information and medications are approved by the FDA.

Who Is on the Pharmacy and Therapeutics Committee and How Are Decisions Made?

The committee is made up of actively practicing Physicians of various medical specialties from Health Net Physician Groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Essential Drug List. The voting members are not employees of Health Net. This ensures that decisions are unbiased and without conflict of interest.

Step Therapy

Step therapy is a process in which you may need to use one type of Prescription Drug before Health Net will cover another one. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost-effective Prescription Drugs. Exceptions to the step therapy process are subject to Prior Authorization. However, if you were taking a Prescription Drug for a medical condition under a previous plan before enrolling in this HMO Plan, you will not be required to use the step therapy process to continue using the Prescription Drug.

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the Prescription Drug prescribed by a health care provider for a Member. For more information on the step therapy exception process, please see "Step Therapy Exception" in the Essential Drug List on www.healthnet.com.

Prior Authorization and Step Therapy Exception Process for Prescription Drugs

Prior Authorization status is included in the Essential Drug List - The Essential Drug List identifies which drugs require Prior Authorization or step therapy. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net. Step therapy exceptions are also subject to the Prior Authorization process.

You may obtain a list of drugs requiring Prior Authorization by visiting our website at www.healthnet.com or call the Customer Contact Center at the telephone number on your Health Net ID card. If a drug is not on the Essential Drug List, your Physician should call Health Net to determine if the drug requires Prior Authorization.

Brand Name Drugs that have generic equivalents also require Prior Authorization. Health Net will cover Brand Name Drugs that have generic equivalents when Medically Necessary and the Physician obtains approval from Health Net.

Requests for Prior Authorization, including step therapy exceptions, may be submitted electronically or by telephone or facsimile. Urgent requests from Physicians for authorization are processed and prescribing providers are notified of Health Net's determination as soon as possible, not to exceed 24 hours, whichever is less, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A Prior Authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from Physicians are processed and prescribing providers notified of Health Net's determination in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decision. If Health Net fails to respond within the required time limit the Prior Authorization request is deemed granted.

Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact Health Net to obtain the usage guidelines for specific medications.

Once a medication is approved, its authorization becomes effective immediately.

If the Prior Authorization or step therapy exception request is approved, drugs will be covered, including refills, as shown in the "Schedule of Benefits and Copayments" section. If the Prior Authorization or step therapy exception is denied, the drug is not covered, and you are responsible for the entire cost of the drug.

If you are denied Prior Authorization, please refer to the "Grievance, Appeals, Independent Medical Review and Arbitration" portion of the "General Provisions" section of this *Evidence of Coverage*.

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

Except as described below under "Nonparticipating Pharmacies and Emergencies" and "Drugs Dispensed by Mail Order," you must purchase covered drugs at a Participating Pharmacy.

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy please visit our website at www.healthnet.com or call the Customer Contact Center at the telephone number on your Health Net ID card. Present the Health Net ID card and pay the appropriate Copayment when the drug is dispensed.

Up to a 30-consecutive-calendar-day supply is covered for each Prescription Drug Order. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. 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. See also the "Schedule II Narcotic Drugs" portion of the "Exclusions and Limitations" section.

If the Health Net ID card is not available or eligibility cannot be determined:

- Pay the entire cost of the drug; and
- Submit a claim for possible reimbursement.

Health Net will reimburse you for the cost of the Prescription Drug, less any required Copayment shown in the "Schedule of Benefits and Copayments" section of this *Evidence of Coverage*.

Except as described below in "Nonparticipating Pharmacies and Emergencies," for new Members and emergent care, if you elect to pay out-of-pocket and submit a prescription claim directly to Health Net instead of having the contracted pharmacy submit the claim directly to Health Net, you will be reimbursed based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription, less any applicable Copayment or Deductible.

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID card. After 30 days, Prescription Drugs dispensed by a Nonparticipating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in the "Definitions" section of this *Evidence of Coverage*.

If the above situations apply to you:

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to Health Net for possible reimbursement.

Health Net will reimburse you Prescription Drug covered expenses, less any required Copayment shown in the "Schedule of Benefits and Copayments" section of this *Evidence of Coverage*.

If you present a Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available. In cases of Emergency Care or Urgently Needed Care, you should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

There are no benefits through Nonparticipating Pharmacies after 30 days of coverage or if the Prescription Drug was not purchased for Emergency Care or Urgently Needed Care.

Note(s):

The "Prescription Drug" portion of the "Exclusions and Limitations" section of this *Evidence of Coverage* and the requirements of the Essential Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at www.healthnet.com.

Drugs Dispensed by Mail Order

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 a drug treatment plan with a specific medication at a constant dosage requirement. To receive Prescription Drugs by mail, send the following to the designated mail order administrator:

- The completed Prescription Mail Order Form;
- The original Prescription Drug Order (not a copy) written for up to a 90-consecutive-calendar-day-supply of a Maintenance Drug, when appropriate; and
- The appropriate Copayment.

You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

The mail order administrator may dispense up to a 90-consecutive-calendar-day supply of a covered Maintenance Drug and each refill allowed by that order. The required Copayment applies each time a drug is dispensed. In some cases, a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the mail order may be less than a 90-consecutive-calendar-day supply.

Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.

Note(s):

Tier 4 Drugs (Specialty Drugs) and Schedule II narcotic drugs are not covered through our mail order program. Refer to the Prescription Drug portion of the “Exclusions and Limitations” section for more information.

Acupuncture Services

Please read "Acupuncture Services" portion of the "Exclusions and Limitations" section.

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Acupuncture Services for you. You may access any Contracted Acupuncturist without a referral from a Physician or your Primary Care Physician.

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:

- 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 may be subject to verification of Medical Necessity 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.

The following benefits are provided for Acupuncture Services:

Office Visits

- A new patient exam or an established patient exam is performed by a Contracted Acupuncturist for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Acupuncture Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.

  Established patient exams are performed by a Contracted Acupuncturist to assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam must be Medically Necessary.

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a re-examination, and other services, in various combinations. A Copayment will be required for each visit to the office.

Second Opinion

If you would like a second opinion with regard to covered services provided by a Contracted Acupuncturist, you will have direct access to any other Contracted Acupuncturist. Your visit to a Contracted Acupuncturist for purposes of obtaining a second opinion will count as one visit, for purposes of any maximum benefit and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Contracted Acupuncturist. However, a visit to a second

Contracted Acupuncturist to obtain a second opinion will not count as a visit, for purposes of any maximum benefit, if you were referred to the second Contracted Acupuncturist by another Contracted Acupuncturist (the first Contracted Acupuncturist). The visit to the first Contracted Acupuncturist will count toward any maximum benefit.

Pediatric Vision Services

Please read the "Pediatric Vision Services" portion of the "Exclusions and Limitations" section.

The pediatric vision services benefits are provided by Health Net. Health Net contracts with *EyeMed Vision Care, LLC* to administer the pediatric vision services benefits.

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

All pediatric vision covered services must be provided by a Health Net Participating Vision Provider in order to receive benefits under this Plan. Call the Pediatric Vision Services Customer Contact Center at **866-392-6058** for a listing of Participating Vision Providers or visit our website at www.healthnet.com. This Plan does not cover services and materials provided by a provider who is not a Participating Vision Provider. The Participating Vision Provider is responsible for the provision, direction, and coordination of the Member's complete vision care.

When you receive benefits from a Participating Vision Provider you only pay the applicable Copayment amount that is stated in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section. For materials, you are responsible for payment of any amount in excess of the allowance specified in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section.

Examination

Routine optometric or ophthalmic vision examinations (including refractions) by a licensed Optometrist or ophthalmologist, for the diagnosis and correction of vision, up to the maximum number of visits stated in the "Schedule of Benefits and Copayments" section. Vision examination includes dilation, if professionally indicated.

Contact Lens Fit and Follow-up Examination

If the Member requests or requires contact Lenses, there is an additional examination for contact lens fit and follow-up as stated in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section. Follow-up exam(s) for contact Lenses include subsequent visit(s) to the same provider who provided the initial contact lens fit exam.

Standard contact lens fit and follow-up applies to routine application soft, spherical, daily wear contact Lenses for single vision prescriptions. Standard contact lens fit and follow-up does not include extended or overnight wear for any prescription.

Premium contact lens fit and follow-up applies to complex applications, including, but not limited to, toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable. Premium contact lens fit and follow-up includes extended and overnight wear for any prescription.

Low Vision

This Plan covers one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers, telescopes, and Follow-Up Care (limited to 4 visits every 5 years and a maximum charge of $100 each follow-up visit).

Materials - Frames

If an examination indicates the necessity of Eyeglasses, this vision benefit will cover one frame, up to the maximum number described in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section. See the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section for limitations.

Materials - Eyeglass Lenses

If an examination results in corrective Lenses being prescribed for the first time or if a current wearer of corrective Lenses needs new Lenses, this vision Plan will cover a pair of Lenses subject to the benefit maximum as specified in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section.

Cosmetic Contact Lenses

Eyewear, including contact Lenses, is only covered when there is a need for vision correction.

Medically Necessary Contact Lenses

Coverage for prescriptions for Medically Necessary contact Lenses is subject to Medical Necessity.

Contact Lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

For coverage of Medically Necessary contact Lenses to treat conditions of aniridia, see the "Durable Medical Supplies" under the "Medical Services and Supplies" portion of "Covered Services and Supplies."

Subnormal or Low Vision Services and Aids

Health Net covers low vision services, supplemental testing/exam, Follow-Up Care, and aids, including high-power spectacles, magnifiers, and telescopes.

Contact Lenses for Conditions of Aphakia

Special contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact Lenses for that eye during the same Calendar Year. For adults age 19 and older, see the "Durable Medical Equipment" portion of "Covered Services and Supplies" for coverage details.

Pediatric Dental Services

Please read the* "Pediatric Dental Services" portion of the "Exclusions and Limitations" *section.

Except as otherwise provided below, all benefits must be provided by the Member's Primary Dentist in order to receive benefits under this dental Plan. This dental Plan does not provide benefits for services and supplies provided by a dentist who is not the Member's Primary Dentist, except as specifically described under the "Pediatric Dental Services" portion of the "Introduction to Health Net" section.

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

Choice of Provider

When you enroll, you must choose a selected general dentist from our network. Please refer to the directory of Participating Dentists for a complete listing of selected general dentists.

Facilities

A complete list of contracted facilities is contained in the provider directory. You may obtain an updated provider directory by calling Customer Service at (866) 249-2382 or at www.healthnet.com.

Medically Necessary Dental Services

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

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of the teeth and supporting tissues of the teeth.

New Patient and Routine Services

As a Member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the selected general dentist may need additional time to meet your special request.

Making an Appointment

Once your coverage begins, you may contact the selected general dentist you selected at enrollment to schedule an appointment. Selected general dentists' offices are open in accordance with their individual practice needs. When scheduling an appointment, please identify yourself as a Member. Your selected general dentist will also need to know your chief dental concern and basic personal data. Arrive early for your first appointment to complete any paperwork. There is an office visit Copayment on some plans and also be aware that there is a charge for missing your appointment. Your first visit to your dentist will usually consist of x-rays and an examination only. By performing these procedures first, your dentist can establish your treatment plan according to your overall health needs.

We recommend that you take this brochure with you on your appointment, along with the enclosed "Schedule of Benefits and Copayments." Remember, only pediatric dental services listed as covered

benefits in the "Schedule of Benefits and Copayments" and provided by a selected general dentist are covered.

Specialist Referrals

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

Teledentistry Benefits

This dental Plan covers Medically Necessary Teledentistry benefits as described in the "Pediatric Dental Services" portion of the "Schedule of Benefits and Copayments." Teledentistry services must be provided by a Participating Dentist from our network.

Orthodontic Benefits

This dental Plan covers orthodontic benefits as described in the "Pediatric Dental Services" portion of the "Schedule of Benefits and Copayments." Extractions and initial diagnostic x-rays are not included in these fees. Orthodontic treatment must be provided by a Participating Dentist.

Referrals to Specialists for Orthodontic Care

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

Changing Your Selected General Dentist

You have control over your choice of dental offices, and you can make changes at any time. If you would like to change your selected general dentist, please contact Customer Service at (866) 249-2382. Our associates will help you locate a dental office most convenient to you. The transfer will be effective on the first day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

Second Opinions

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. Contact our Customer Service Department either by calling Customer Service at **(866) 249-2382** or sending a written request to the following address:

Health Net Dental
c/o Dental Benefit Providers of California, Inc.
Dental Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569
Fax: 714-364-6266

In addition, your selected general dentist may also request a second opinion on your behalf. There is no second opinion consultation charge to you. You will be responsible for the office visit Copayment as listed on your "Schedule of Benefits and Copayments." Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

- If you question the reasonableness or necessity of recommended surgical procedures.
- If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a Serious Chronic Condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
- If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

Requests for second opinions are processed within five (5) business days of receipt of such request, except when an expedited second opinion is warranted; in which case a decision will be made and conveyed to you within 24 hours. Upon approval, we will contact the consulting dentist and make arrangements to enable you to schedule an appointment. All second opinion consultations will be completed by a contracted dentist with qualifications in the same area of expertise as the referring dentist or dentist who provided the initial examination or dental care services. You may obtain a copy of the second dental opinion policy by contacting our Customer Service Department by telephone at the toll-free number indicated above, or by writing to us at the above address. No Copayment is required for a second opinion consultation. Some plans do require a Copayment for an office visit.

Copayments

When you receive care from either a selected general dentist or Specialist, you will pay the Copayment described on your "Schedule of Benefits and Copayments" enclosed with this *Evidence of Coverage*. When you are referred to a Specialist, your Copayment may be either a fixed dollar amount, or a percentage of the dentist's usual and customary fee. Please refer to the "Schedule of Benefits and Copayments" for specific details. When you have paid the required Copayment, if any, you have paid in full. If we fail to pay the contracted provider, you will not be liable to the provider for any sums owed by us. If you choose to receive services from a noncontracted provider, you may be liable to the noncontracted provider for the cost of services unless specifically authorized by us or in accordance with Emergency Care provisions. We do not require claim forms.

Dental Customer Service

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your dental office. Customer Service can be reached Monday through Friday at **(866) 249-2382** from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and dental office transfers.

Mental Health and Substance Use Disorders

The coverage described below complies with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Certain limitations or exclusions may apply. Please read the "Exclusions and Limitations" section of this Evidence of Coverage.

In order for a Mental Health or Substance Use Disorder service or supply to be covered, it must be Medically Necessary and authorized, if required, by Health Net.

When you need to see a Participating Mental Health Professional, contact the Health Net Customer Contact Center at the phone number on your Health Net ID card.

Certain services and supplies for Mental Health and Substance Use Disorders require Prior Authorization by Health Net to be covered. The services and supplies that require Prior Authorization are:

- Outpatient procedures that are not part of an office visit (for example: psychological and neuropsychological testing, outpatient electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS)), partial hospitalization, day treatment, half-day partial hospitalization and gender affirming care;
- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing, intensive outpatient services and gender affirming surgery; and
- Behavioral health treatment for pervasive developmental disorder or autism (see below under "Outpatient Services").

Health Net will help you identify a nearby Participating Mental Health Professional, participating independent Physician within the network and with whom you can schedule an appointment, as discussed in the "Introduction to Health Net" section. The designated Participating Mental Health Professional, independent Physician will evaluate you, develop a treatment plan for you, and submit that treatment plan to Health Net for review. Upon review and authorization (if authorization is required) by Health Net, the proposed services will be covered by this Plan if they are determined to be Medically Necessary.

If services under the proposed treatment plan are determined by Health Net to not be Medically Necessary, as defined in the "Definitions" section, services and supplies will not be covered for that condition. However, Health Net may direct you to community resources where alternative forms of assistance are available. See the "General Provisions" section for the procedure to request an independent medical review of a Plan denial of coverage. Medically Necessary speech, occupational and physical therapy services are covered under the terms of this Plan, regardless of whether community resources are available.

For additional information on accessing Mental Health and Substance Use Disorder services, visit our website at www.healthnet.com or contact the Health Net Customer Contact Center phone number shown on your Health Net ID card.

In an emergency, call **911** or go to the nearest Hospital. If your situation is not so severe, or if you are unsure of whether an emergency condition exists, you may call Health Net at the Customer Contact Center telephone number shown on your Health Net ID card. You can also call 988, the national suicide and mental health crisis hotline system. Please refer to the "Emergency and Urgently Needed Care" portion of the "Introduction to Health Net" section for more information.

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Net fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require Prior Authorization for the appointment) or within 96 hours (if the health plan does require Prior Authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services, you can: (1) call your health plan at the telephone number on the back of your health plan identification card; (2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or (3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic Mental Health or Substance Use Disorder condition from a non-Participating Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with Health Net, subject to applicable Copayments and any other exclusions and limitations of this Plan.

Your non-Participating Mental Health Professional must be willing to accept Health Net's standard Mental Health or Substance Use Disorder provider contract terms and conditions and be located in the Plan's service area.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Request Form or our continuity of care policy, please call the Customer Contact Center at the telephone number on your Health Net ID card.

The following benefits are provided:

Outpatient Services

Outpatient services are covered as shown in the "Schedule of Benefits and Copayments" section under "Mental Health and Substance Use Disorder Benefits."

Covered services include:

- Outpatient office visits/professional consultation including substance use disorders: Includes outpatient crisis intervention, short-term evaluation and therapy, medication management (including detoxification), drug therapy monitoring, longer-term specialized therapy and individual and group Mental Health and Substance Use Disorder evaluation and treatment.

- Outpatient services other than an office visit/professional consultation including substance use disorders: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Health or Substance Use Disorder, intensive outpatient care program, day treatment, partial hospitalization program and other outpatient procedures/services including, but not limited to, laboratory services or rehabilitation when provided for Mental Health or Substance Use Disorder conditions. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral health treatment for pervasive developmental disorder or autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with pervasive developmental disorder or autism, as shown in the "Schedule of Benefits and Copayments" section, under "Mental Health and Substance Use Disorder Benefits."
  - The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.
  - A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to Health Net.
  - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
  - The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
  - Health Net may deny coverage for treatment if the requirements above are not met or if efficacy of the treatment is not demonstrated.

Second Opinion

You may request a second opinion when:

- Your Participating Mental Health Professional renders a diagnosis or recommends a treatment plan that you are not satisfied with;

- You are not satisfied with the result of the treatment you have received;
- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including, but not limited to, a Serious Chronic Condition;
- Your Primary Care Physician or a referral Physician is unable to diagnose your condition or test results are conflicting;
- The treatment plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care; or
- If you have attempted to follow the plan of care, you consulted with the initial Primary Care Physician or a referral Physician due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion, contact Health Net. Participating Mental Health Professionals will review your request in accordance with Health Net's second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments. You may obtain a copy of this policy from the Customer Contact Center.

Second opinions will only be authorized for Participating Mental Health Professionals, unless it is demonstrated that an appropriately qualified Participating Mental Health Professional is not available. Health Net will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Any service recommended must be authorized by Health Net in order to be covered.

Inpatient Services

Inpatient treatment of a Mental Health or Substance Use Disorder is covered as shown in the "Schedule of Benefits and Copayments" section under "Mental Health and Substance Use Disorder Benefits."

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary Mental Health and Substance Use Disorder services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations" section.

Detoxification and Treatment of Withdrawal Symptoms

Inpatient and outpatient services for detoxification, withdrawal symptoms and treatment of medical conditions relating to substance use disorders are covered, based on Medical Necessity, including room and board, Participating Mental Health Professional services, drugs, dependency recovery services, education and counseling.

Transitional Residential Recovery Services

Transitional residential recovery services for substance use disorders in a licensed recovery home when approved by Health Net are covered.

EXCLUSIONS AND LIMITATIONS

It is extremely important to read this section before you obtain services in order to know what Health Net will and will not cover.

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the *Evidence of Coverage*, exceed *Evidence of Coverage* limitations or are Follow-Up Care (or related to Follow-Up Care) to *Evidence of Coverage* exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic Health Care Service under applicable law, or is required to be covered by other state or federal law, and is Medically Necessary as defined in the "Definitions" section.

General Exclusions and Limitations

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this *Evidence of Coverage*.

Ambulance Services

Air and ground ambulance and ambulance transport services are covered as shown in the "Ambulance Services" provision of the "Covered Services and Supplies" section.

Paramedic, ambulance, or ambulance transport services are not covered in the following situations:

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Care, as defined in "Emergency Care" in the "Definitions" section, were not met, unless authorized by your Physician Group, as discussed in the "Ambulance Services" provision of the "Covered Services and Supplies" section; or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the Plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

Chiropractic Services

This Plan does not cover Chiropractic Services.

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section, coverage for clinical trials does not include the following items:

- The Investigational drug, item, device, or service itself;

- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health Care Services that are specifically excluded from coverage under this *Evidence of Coverage*; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care

This Plan does not cover services and supplies that are provided to assist with the activities of daily living, regardless of where performed.

Custodial Care, as described in the "Definitions" section is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition or provide for the patient's comforts or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant, physical, speech or occupational therapist or other licensed health care provider.

Please see the "Hospice Care" provisions in the "Covered Services and Supplies" and the "Definitions" sections for services that are provided as part of that care, when authorized by the Plan or the Member's contracted Physician Group.

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, except disposable ostomy or urological supplies listed under the "Ostomy and Urological Supplies" portion of the "Covered Services and Supplies" section.

Experimental or Investigational Services

Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section for more information; or
- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Clinical Trials" provision in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Home Birth

A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in this *Evidence of Coverage*, have been met.

Ineligible Status

This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered, except as specified in the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

No-Charge Items

This Plan does not cover reimbursement to the Member for services or supplies for which the Member is not legally required to pay the provider or for which the provider pays no charge.

Personal or Comfort Items

This Plan does not cover personal or comfort items.

Services and Supplies

In addition to the exclusions and limitations shown in the "General Exclusions and Limitations" portion of this section, the following exclusions and limitations apply to services and supplies under the medical benefits and the Mental Health and Substance Use Disorder benefits:

Annual Physical Examinations

This Plan does not cover annual physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes. An annual physical 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. See "Preventive Care Services" in the "Covered Services and Supplies" section for information about coverage of examinations that are for preventive health purposes.

Aqua or Other Water Therapy

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.

Aversion Therapy

Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

Biofeedback

Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders (such as incontinence and chronic Pain) and Mental Health and Substance Use Disorders.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered.

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation, and storage) as such treatments are considered to be Experimental or Investigational in nature. See the "General Provisions" section for the procedure to request an independent medical review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Cosmetic Services and Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Member are not covered. However, the Plan does cover Medically Necessary services and supplies for complications which exceed routine Follow-Up Care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair analysis, hairpieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors or disease, and such surgery does either of the following:

- Improve function;
- Create a normal appearance to the extent possible;

Then, the following are covered:

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to remove or reduce skin or tissue; or
- 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.

In addition, when a Medically Necessary mastectomy (including lumpectomy) has been performed, the following are covered:

- Breast reconstruction surgery; and
- Surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breasts.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the ***Women's Health and Cancer Rights Act of 1998****.*

CVS MinuteClinic Services

Services required for the treatment of Emergency Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit. Please refer to the "Schedule of Benefits and Copayments" section for applicable Copayment requirements for all other services or supplies not covered under the CVS MinuteClinic benefit.

Services or supplies obtained from a CVS MinuteClinic that are not specified as covered in this *Evidence of Coverage* are excluded under this Plan. CVS MinuteClinics are not intended to replace your Primary Care Physician or Specialist Physician as your primary source of regular monitoring of chronic conditions, but MinuteClinics can, for example, provide a blood sugar test for diabetics, if needed.

Dental Services

Dental services or supplies are limited to the following situations except as specified in the "Pediatric Dental Services" portion of "Schedule of Benefits and Copayments" and the "Pediatric Dental Services" portion of the "Covered Services and Supplies" section:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of the "Introduction to Health Net" section for more information. For urgent or unexpected dental conditions that occur after-hours or on weekends, please refer to the "Pediatric Dental Services" portion of "Introduction to Health Net."
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily noncovered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary are subject to the other exclusions and limitations of this *Evidence of Coverage* and will only be covered under the following circumstances (a) Members who are under eight years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- 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.

The following services are not covered under any circumstances, except as specified in the "Pediatric Dental Services" portion of "Covered Services and Supplies," and as described above for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

- Routine care or treatment of teeth and gums including, but not limited to, dental abscesses, inflamed tissue, or extraction of teeth.

- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, or Orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD/TMJ disorders are covered if they are Medically Necessary, as described in the "Disorders of the Jaw" provision of this section.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of the "Covered Services and Supplies" section) or as indicated on the U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations.

Dietary or nutritional supplements and specialized formulas may be covered as deemed Medically Necessary for Mental Health and Substance Use Disorder treatments when the dietary nutritional supplement or specialized formula is a component of a behavioral health treatment plan with a qualified provider for treatment of the Mental Health and Substance Use Disorder diagnosis. Coverage for the dietary or nutritional supplements and specialized formulas must be plan authorized, as required by Health Net or your Physician Group.

Health Net will cover only those Mental Health and Substance Use Disorder 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.

See also "Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies" in the "Prescription Drugs" portion of this section.

Disorders of the Jaw

Treatment for disorders of the jaw is limited to the following situations:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices; orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants or other dental appliances and related surgeries to treat dental conditions are not covered under any circumstances.
- Custom made oral appliances (intra-oral splint or occlusal splint and surgical procedures) to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics inlays or onlays, crowns, bridgework, dental splints, dental implants or other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered, as stated in the "Dental Services" provision of this section.

  TMD is generally caused when the chewing muscles and jaw joint do not work together correctly and may cause headaches, tenderness in the jaw muscles, tinnitus or facial Pain.

Durable Medical Equipment

Although this Plan covers Durable Medical Equipment, it does not cover the following items:

- Appliances or devices for comfort or convenience; or luxury equipment or features.
- Alteration of your residence to accommodate your physical or medical condition, including the installation of elevators.
- Air purifiers, air conditioners and humidifiers.
- Exercise equipment.
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.
- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the "Prostheses" provision of the "Covered Services and Supplies" section and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of the "Covered Services and Supplies" section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary, and custom made for the Member. Corrective Footwear must also be permanently attached to an orthotic device meeting coverage requirements under this Plan.

Fertility Preservation

Standard fertility preservation treatments are covered as shown in the "Fertility Preservation" provision in the "Covered Services and Supplies" section. However, coverage for fertility preservation does not include the following:

- Follow-up Assisted Reproductive Technologies (ART) to achieve future pregnancy such as artificial insemination, in-vitro fertilization, and/or embryo transfer
- Pre-implantation genetic diagnosis
- Donor eggs, sperm, or embryos
- Gestational carriers (surrogates)

Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Biomarker testing is covered when determined by Health Net to be Medically Necessary, including for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. However,

Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer. Genetic testing will not be covered for nonmedical reasons or when a Member has no medical indication. For information regarding genetic testing and diagnostic procedures of a fetus, see the "Pregnancy" portion of the "Covered Services and Supplies" section.

Hearing Aids

This Plan does not cover any analog or digital hearing aid devices, which typically fit in or behind the outer ear and are used to improve hearing.

Immunizations and Injections

This Plan does not cover immunizations and injections for foreign travel/occupational purposes.

Infertility Services

This Plan does not cover services or supplies to diagnose, evaluate or treat Infertility. Excluded procedures include, but are not limited to:

- Conception by medical procedures, such as artificial insemination, In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.

Massage Therapy

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.

Noncovered Treatments

The following types of treatment are only covered when provided in connection with covered treatment for a Mental Health or Substance Use Disorder:

- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

Treatment of neurocognitive disorders which include delirium, major and mild neurocognitive disorders and their subtypes and neurodevelopmental disorders are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms or Substance Use Disorder conditions only if amenable to psychotherapeutic, psychiatric, or Substance Use Disorder treatment. This provision does not impair coverage for the Medically Necessary treatment of any Mental Health or Substance Use Disorder conditions identified as a Mental Health or Substance Use Disorder as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision*, as amended to date.

In addition, Health Net will cover only those Mental Health and Substance Use Disorder 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.

This Plan covers Medically Necessary treatment for all Essential Health Benefits, including "Mental Health and Substance Use Disorders" described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition.

Noneligible Institutions

This Plan only covers Medically Necessary services or supplies provided by a licensed Hospital, Hospice, Medicare-approved Skilled Nursing Facility, Residential Treatment Center, or other properly licensed medical facility specified as covered in this *Evidence of Coverage*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.

Nonstandard Therapies

Services that do not meet national standards for professional medical health or Mental Health and Substance Use Disorder practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, and crystal healing therapy are not covered. Hypnotherapy services are covered as part of a comprehensive evidence-based mental health treatment plan and provided by a licensed mental health provider with a medical hypnotherapy certification.

For information regarding requesting an independent medical review of a denial of coverage see the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section.

Physician Self-Treatment

This Plan does not cover Physician self-treatment rendered in a nonemergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in the "Prescription Drugs" portion of the "Covered Services and Supplies" section.

Private Duty Nursing

This Plan does not cover Private Duty Nursing in the home or for registered bed patients in a Hospital or long-term care facility. Shift care and any portion of shift care services are also not covered.

Psychological Testing

Psychological testing except as conducted by Participating Mental Health Professionals who are licensed and acting within the scope of their license, 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.

Refractive Eye Surgery

This Plan does not cover eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) or astigmatism, unless Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net.

Rehabilitation and Habilitation Therapy

Coverage for rehabilitation 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 their license, to treat physical conditions and Mental Health and Substance Use Disorders, 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. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals. See the "General Provisions" section for the procedure to request an independent medical review of a Plan denial of coverage on the basis of Medical Necessity.

Rehabilitation and habilitation therapy for physical impairments in Members with Mental Health and Substance Use Disorders, including pervasive developmental disorder and autism, that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation or habilitation therapy are met.

Residential Treatment Center

Admission to a Residential Treatment Center that is not Medically Necessary is excluded. Admissions that are not considered Medically Necessary and are not covered include, but are not limited to, admissions for Custodial Care, for a situational or environmental change only; or as an alternative to placement in a foster home or halfway house. This exclusion does not apply when the overnight stay is part of covered care in or a licensed facility providing transitional residential recovery services covered under the "Mental Health and Substance Use Disorder" section of "Covered Services and Supplies."

Routine Foot Care

Routine foot care including callus treatment, corn paring or excision, toenail trimming, massage of any type and treatment for fallen arches, flat or pronated feet are not covered unless Medically Necessary. Additionally, treatment for cramping of the feet, bunions and muscle trauma are excluded, unless Medically Necessary. The Copayment for Medically Necessary covered foot care with a Doctor of Podiatric Medicine (DPM) is the same as a visit to Physician, Physician Assistant or Nurse Practitioner.

Reversal of Surgical Sterilization

This Plan does not cover services to reverse voluntary, surgically induced sterility.

Services for Educational or Training Purposes

Except for services related to behavioral health treatment which are covered as shown in the "Covered Services and Supplies" section, 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. Examples of excluded services include education and training for nonmedical purposes such as:

- Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. For example: The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching Members how to read; educational testing or academic education during residential treatment.
- Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
- Teaching manners or etiquette appropriate to social activities.
- Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for behavioral health treatment as indicated above in conjunction with the diagnosis of pervasive development disorder or autism.

Services Not Related to Covered Condition, Illness or Injury

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 or supplies for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an Emergency Care or Urgently Needed Care as defined in the "Definitions" section.

Sports Activities

The costs associated with participating in sports activities, including, but not limited to, yoga, rock climbing, hiking and swimming, are not covered.

Surrogate Pregnancy

This Plan covers services for a surrogate pregnancy only 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. A surrogate pregnancy is one in which a person has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision are subject to the Plan's right to recovery as described in "Surrogacy Arrangements" in the "General Provisions" section of this *Evidence of Coverage*.

Telehealth Consultations Through the Select Telehealth Services Provider

Telehealth consultation through a Select Telehealth Services Provider do not cover:

- Specialist services; and
- Prescriptions for substances controlled by the DEA, nontherapeutic drugs or certain other drugs which may be harmful because of potential for abuse.

Treatment by Immediate Family Members

This Plan does not cover routine or ongoing treatment, consultation or provider referrals (including, but not limited to, prescribed services, supplies and drugs) provided by the Member's parent, spouse, Domestic Partner, child, stepchild or sibling. Members who receive routine or ongoing care from a member of their immediate family will be reassigned to another Physician at the contracting Physician Group (medical) or a Participating Mental Health Professional (Mental Health or Substance Use Disorders).

Treatment of Obesity

Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity. Certain services may be covered as Preventive Care Services; refer to the "Preventive Care Services" provision in "Covered Services and Supplies."

Treatment Related to Judicial or Administrative Proceedings

Medical and Mental Health or Substance Use Disorder services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary covered services.

Exception(s):

The Plan will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all Health Care Services for a Member when required or recommended for the Member pursuant to a Community Assistance, Recovery, and Empowerment (CARE) agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. Services are provided to the Member with no cost share or Prior Authorization, except for Prescription Drugs. Prescription Drugs are subject to the cost share shown in the "Schedule of Benefits and Copayments" and may require Prior Authorization.

Unauthorized Services and Supplies

This Plan only covers services or supplies that are authorized by Health Net or the Physician Group (medical) or Health Net (Mental Health or Substance Use Disorders) according to Health Net's procedures, except for emergency services.

Services or supplies that are rendered by a noncontracting provider or facility are only covered when authorized by your Physician Group (medical), Health Net (Mental Health or Substance Use Disorders) or when you require Emergency Care or Urgently Needed Care.

Vision Therapy, Eyeglasses and Contact Lenses

This Plan does not cover vision therapy, Eyeglasses or contact Lenses except as specified in the "Pediatric Vision Services" portion of the "Covered Services and Supplies" section. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Prescription Drugs

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section also apply to the coverage of Prescription Drugs.

Note(s):

Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for more information.

Additional exclusions and limitations:

Allergy Serum

Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See the "Allergy, Immunizations and Injections" portion of the "Schedule of Benefits and Copayments" section and the "Immunizations and Injections" portion of the "Covered Services and Supplies" section.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs prescribed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. In such cases the drug will be subject to Prior Authorization from Health Net.

Brand Name Drugs that have Generic Equivalents

Brand Name Drugs that have generic equivalents are not covered without Prior Authorization from Health Net.

Devices

Coverage is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers and those devices listed under the "Diabetic Drugs and Supplies" provision of the "Prescription Drugs" portion of the "Covered Services and Supplies" section. No other devices are covered even if prescribed by a Member Physician.

Diagnostic Drugs

Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Dietary or Nutritional Supplements

Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product, are limited to drugs that are listed in the Essential Drug List and are subject to Prior Authorization from Health Net.

Phenylketonuria (PKU) treatment is covered under the medical benefit (see the "Phenylketonuria" portion of the "Covered Services and Supplies" section).

Drugs Prescribed for the Common Cold

Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

Drugs Prescribed for Cosmetic or Cognitive Performance Purposes

Drugs that are prescribed for the following nonmedical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and cognitive performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Retin-A, Vaniqa, Propecia, or Lustra. This exclusion does not exclude coverage for drugs when Prior Authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including, but not limited to, Alzheimer's dementia.

Food and Drug Administration (FDA)

Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except as described under the "Clinical Trials" provision in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section and the "Experimental or Investigational Services" portion of this "Exclusions and Limitations" section.

Hypodermic Syringes and Needles

Hypodermic syringes and needles are limited to disposable insulin needles and syringes and specific brands of pen devices and pen needles. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net's specialty pharmacy vendor under the medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies" section). All other syringes, devices and needles are not covered.

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs

Once you have taken possession of drugs, replacement of lost, stolen or damaged drugs is not covered. You will have to pay the retail price for replacing them.

Nonapproved Uses

Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the "Off-Label Drugs" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section).

Noncovered Services

Drugs prescribed for a condition or treatment that is 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).

Nonparticipating Pharmacies

Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "COVID-19 Outpatient Services" and the "Nonparticipating Pharmacies and Emergencies" provisions of the "Covered Services and Supplies" section.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for contraception, as approved by the FDA.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies 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 unless it is listed in the Essential Drug List. However, if a higher dosage form of a non-Prescription Drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

Physician Is Not a Member Physician

Drugs prescribed by a Physician who is not a Member Physician or an authorized Specialist are not covered, except when the Physician's services have been authorized or because of an Emergency Medical Condition, illness or injury or as specifically stated.

Quantity Limitations

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.

Schedule II Narcotic Drugs

Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Member Physician. Partial prescription fills are subject to a prorated Copayment based on the amount of the prescription that is filled by the pharmacy. Schedule II narcotic drugs are not covered through mail order.

Self-Injectable Drugs

Self-injectable drugs obtained through a prescription from a Physician are limited to insulin, sexual dysfunction drugs and injections listed on the Essential Drug List. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies" section). Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of the "Covered Services and Supplies" section).

Sexual Dysfunction Drugs

Drugs (including injectable medications) when on the Essential Drug List and Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30-day period.

Unit Dose or "Bubble" Packaging

Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Acupuncture Services

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section also apply to Acupuncture Services.

Note(s):

Services or supplies excluded under the acupuncture benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for more information.

Services, laboratory tests, x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH Plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Auxiliary Aids

Auxiliary aids and services are not covered. This includes but is not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

Diagnostic Radiology

No diagnostic radiology (including x-rays, magnetic resonance imaging or MRI) is covered.

Drugs

Prescription Drugs and over-the-counter drugs are not covered.

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Acupuncture Services

Acupuncture care that is (a) investigatory; or (b) an unproven Acupuncture Service that does not meet generally accepted and professionally recognized standards of practice in the acupuncture provider community is not covered. ASH Plans will determine what will be considered Experimental or Investigational.

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Anesthesia

Charges for anesthesia are not covered.

Hypnotherapy

Hypnotherapy, sleep therapy, behavior training and weight programs are not covered.

Non-Contracted Providers

Services or treatment rendered by acupuncturists who do not contract with ASH Plans are not covered, except upon referral by ASH Plans.

Thermography

The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs

Transportation costs are not covered, including local ambulance charges.

X-ray and Laboratory Tests

X-ray and laboratory tests are not covered.

Medically/Clinically Unnecessary Services

Only Acupuncture Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Services Not Within License

Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also

sometimes called “ear candling,” involves the insertion of one end of a long, flammable cone (“ear cone”) into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called “Oriental Bodywork” or “Chinese Bodywork Therapy,” utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

Vitamins

Vitamins, minerals, nutritional supplements or other similar products are not covered.

Pediatric Vision Services

The exclusions and limitations in the “Services and Supplies” and “Medical Services and Supplies” portions of this section apply to pediatric vision services.

Note(s):

Services or supplies excluded under the vision benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the “Medical Services and Supplies” portion of the “Covered Services and Supplies” section for more information.

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

Additional exclusions and limitations:

Nonparticipating Providers

This vision Plan will **not** cover services and supplies provided by a provider who is not a Participating Vision Provider.

Not-Medically Necessary Services and Materials

Charges for services and materials that Health Net determines to be non-Medically Necessary services, are excluded. One routine eye examination with dilation is covered every Calendar Year, and is not subject to Medical Necessity.

Medically Necessary Contact Lenses

Coverage for prescriptions for contact Lenses is subject to Medical Necessity. 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. See the “Pediatric Vision Services” portions of “Schedule of Benefits and Copayments” and “Covered Services and Supplies” for details.

Medical or Hospital

Hospital and medical charges of any kind, vision services rendered in a Hospital and medical or surgical treatment of the eyes, are not covered.

Loss or Theft

Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this Plan.

Orthoptics, Vision Training, etc.

Orthoptics and vision training and any associated testing, subnormal vision aids, plano (nonprescription) Lenses, Lenses are excluded unless specifically identified as a covered service in the "Pediatric Vision Services" portion of the "Schedule of Benefits and Copayments" section.

Second Pair

A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

Employment Related

Any services or materials as a condition of employment (e.g., safety glasses). Noted Exception: If the service is determined to be Medically Necessary, irrespective of whether a condition of employment also requires it, the service is covered.

Medical Records

Charges associated with copying or transferring vision records are excluded. Noted Exception: If Health Net's contracting provider terminates, lacks capacity or the enrollee is transferred for other good cause, the enrollee is not required to pay the charges associated with copying or transferring vision records to the participating provider in order to obtain covered services.

Pediatric Dental Services

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to pediatric dental services. See the "Pediatric Dental Services" portion of the "Schedule of Benefits and Copayments" section for additional limitations.

Note(s):

Services or supplies excluded under the dental benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," for more information.

***Except as otherwise provided in the "Pediatric Dental Services" portion of "Covered Services and Supplies,"* all benefits must be provided by the Member's Primary Dentist in order to receive benefits under this dental Plan. This dental Plan does not provide benefits for services and supplies provided by a dentist who is not the Member's Primary Dentist, except as specifically described under the "Pediatric Dental Services" portion of the "Introduction to Health Net" section.**

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

Additional exclusions and limitations:

Implant Services (D6000-D6199)

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for Medical Necessity.

Medically Necessary Orthodontia (D8000-D8999)

Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a Member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

a. Only those cases with permanent dentition shall be considered for Medically Necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

b. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

c. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed Specialist on their professional letterhead.

d. The automatic qualifying conditions are:

    i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,

    ii. Craniofacial anomaly. Written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,

    iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

    iv. A crossbite of individual anterior teeth causing destruction of soft tissue,

    v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

    vi. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the Prior Authorization request.

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

Adjunctive Services (D9000-D9999)

Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards:

a. Palliative treatment (relief of Pain).

b. Palliative (emergency) treatment, for treatment of dental Pain, limited to once per day, per Member.

c. House/extended care facility calls, once per Member per date of service.

d. One Hospital or ambulatory surgical center call per day per provider per Member.

e. Anesthesia for Members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when Prior Authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require Prior Authorization.

f. Occlusal guards when Medically Necessary and Prior Authorized, for Members from 12 to 19 years of age when Member has permanent dentition.

Services which, in the opinion of the attending dentist or Health Net, are not Medically Necessary

The following services, if in the opinion of the attending dentist or Health Net are not Medically Necessary, will not be covered:

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or b) is inconsistent with generally accepted standards for dentistry.
- 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. Experimental treatment if denied may be appealed through the independent medical review process and that service shall be covered and provided if required under the independent medical review process. Please refer to the “Independent Medical Review of Investigational or Experimental Therapies” portion of the “General Provisions” section set forth in the *Evidence of Coverage* for your health Plan with Health Net for more information.
- General anesthesia or intravenous/conscious sedation, except as specified in the medical benefits portion of this *EOC*. See the “Exclusions and Limitations” under the “Dental Services” 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 their panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or their 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 Member reasonably should have known that an Emergency Care situation did not exist.

Missed Appointments

Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.

GENERAL PROVISIONS

When the Plan Ends

The Group Service Agreement specifies how long this Plan remains in effect.

If you are totally disabled on the date that the Group Service Agreement is terminated, benefits will continue according to the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section.

When the Plan Changes

Subject to notification and according to the terms of the Group Service Agreement, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions and eligibility provisions.

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under the "Eligibility, Enrollment and Termination" section, "When Coverage Ends" regarding termination for nonpayment, Health Net will not provide notice of such changes to Plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to Plan Subscribers.

If you are confined in a Hospital when the Group Service Agreement is modified, benefits will continue as if the Plan had not been modified, until you are discharged from the Hospital.

Form or Content of the Plan: No agent or employee of Health Net is authorized to change the form or content of this Plan. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.

Members' Rights, Responsibilities and Obligations Statement

Health Net is committed to treating Members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted these Members' rights and responsibilities. These rights and responsibilities apply to Members' relationships with Health Net, its contracting practitioners and providers, and all other health care professionals providing care to its Members.

Members have the right to:

- Receive information about Health Net, its services, its practitioners and providers and Members' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to you;

- Use interpreters who are not your family members or friends;
- File a complaint if your language needs are not met;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility and obligation to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed upon with their practitioners;
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Refrain from submitting false, fraudulent, or misleading claims or information to Health Net or your providers.

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

Appeal, complaint or grievance means any dissatisfaction expressed by you or your representative concerning a problem with Health Net, a medical provider or your coverage under this *EOC*, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination, as applicable to this Group health plan, means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net Plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-800-522-0088** or by submitting a Member grievance form through the Health Net website at www.healthnet.com. You may also file your complaint in writing by sending information to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the acupuncture program, call the Health Net Customer Contact Center at **1-800-522-0088** or write to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the pediatric vision services, call Health Net at **1-866-392-6058** or write to:

Health Net
Attention: Customer Contact Center
P.O Box 8504
Mason, OH 45040-7111

If your concern involves pediatric dental services, call Customer Service at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130-0569

For grievances filed for reasons other than cancellation or nonrenewal of coverage you must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. For grievances filed regarding cancellation or nonrenewal of coverage, you must file your grievance with Health Net within 180 days of the termination notice. Please include all information from your Health Net identification card and the details of the concern or problem.

We will:

- For grievances filed for reasons other than cancellation or nonrenewal of coverage, confirm in writing within five calendar days that we received your request. For grievances filed regarding cancellation, rescission or nonrenewal of coverage, confirm in writing within three calendar days that we received your request.
- For grievances filed for reasons other than cancellation or nonrenewal of coverage, review your complaint and inform you of our decision in writing within 30 days from the receipt of the grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the Department of Managed Health Care for assistance or to request an independent medical review, or you may initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed Health Care Services from the Department of Managed Health Care (Department) if you believe that Health Care Services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any Health Care Service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

- Your provider has recommended a Health Care Service as Medically Necessary; you have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of the provider recommendation, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;
- The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the Health Care Service is not Medically Necessary; and
- You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review, you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For nonurgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process, or to request an application form, please call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.
2. Your Physician must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by Health Net.
3. Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or, as an alternative, you submit a request for a therapy that, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
4. You have been denied coverage by Health Net for the recommended or requested therapy.
5. If not for Health Net's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(1-800-522-0088)** and use your health plan's grievance process before contacting the department. Utilizing

this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD** line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Binding Arbitration

As a condition to becoming a Health Net Member, **YOU AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF YOUR HEALTH NET MEMBERSHIP TO FINAL BINDING ARBITRATION, EXCEPT AS THOSE DESCRIBED BELOW AND YOU AGREE NOT TO PURSUE ANY CLAIMS ON A CLASS ACTION BASIS. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding bilateral arbitration as the final means of resolving disputes** that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically, such disputes are handled and resolved through the Health Net grievance, appeal and independent medical review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000. In the event that total amount of damages is over $500,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Legal Department at the address provided above.

Members who are enrolled in an employer's Plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician or the contracting Physician Group.

  Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.

- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.
- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, their office staff, the contracting Physician Group or Health Net personnel.
- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-Physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S. the treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org/.) Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

Health Net will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Technology Assessment

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

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

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

Health Net and the health care providers that provide services to you through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident; or
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including, but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers' Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, Health Net's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this Plan, you also grant Health Net an assignment of your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such medical payments carriers to directly reimburse the Plan on your behalf.

STEPS YOU MUST TAKE

If you are injured because of a responsible party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan; and
- Hold any money that you or your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, Hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and as summarized below, will be calculated in accordance with California Civil Code, Section 3040, or as otherwise permitted by law.

- The amount of the reimbursement that you owe Health Net, or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net, or the Physician Group will also be reduced a prorated share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.

* *Reimbursement related to Workers' Compensation benefits, ERISA plans, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Evidence of Coverage and applicable law.*

Surrogacy Arrangements

A surrogacy arrangement is an arrangement in which a person agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to Health Net

If you enter into a surrogacy arrangement, you must pay us for covered services and supplies you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments you and/or any of your Family Members are entitled to receive under the surrogacy arrangement. You also agree to pay us for the covered services and supplies that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if you provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to Health Net in advance of delivery, you will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Duty to Cooperate

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

Surrogacy Third Party Liability – Product Support
The Rawlings Company
One Eden Parkway
LaGrange, KY 40031-8100

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to your surrogacy arrangement and to satisfy Health Net's rights.

You must do nothing to prejudice the health Plan's recovery rights. You must also provide us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member 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 this Plan.

The Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees or of Physician Groups, 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 this Plan.

Provider/Patient Relationship

Member Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges

While it is not likely, it is possible that Health Net may be unable to pay a Health Net provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with Health Net. You may be held liable for the cost of services or supplies received from a noncontracting provider if Health Net does not pay that provider.

This provision does not affect your obligation to pay any required Copayment or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability

Health Net will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing or use of any Prescription Drug this Plan covers.

Continuity of Care Upon Termination of Provider Contract

If Health Net’s contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a Physician Group 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 5 days after the effective date of the contract termination.

In addition, a 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);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later;
- 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.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see the "Definitions" section of this *Evidence of Coverage*.

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.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

Contracting Administrators

Health Net may designate or replace any contracting administrator that provides the covered services and supplies of this Plan. If Health Net designates or replaces any administrator and as a result procedures change, Health Net will inform you.

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this *Evidence of Coverage*.

Decision-Making Authority

Health Net has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Coordination of Benefits

The Member's coverage is subject to the same limitations, exclusions and other terms of this Evidence of Coverage whether Health Net is the Primary Plan or the Secondary Plan.

Coordination of benefits (COB) is a process, regulated by law, that determines financial responsibility for payment of allowable expenses between two or more group health Plans.

Allowable expenses are generally the cost or value of medical services that are covered by two or more group health Plans, including two Health Net Plans.

The objective of COB is to ensure that all group health Plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health Plan provides benefits in the form of services rather than cash payments.

Health Net's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between the two HMOs or insurers. However, you may occasionally be asked to provide information about your other coverage.

This "Coordination of Benefits" provision applies when a Member has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules below determine which Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group Plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions apply to the coverage provided under this subsection only.

A. "**Plan**" - A Plan is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
   1. **"Plan" includes** group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

      (Medicare is not included as a Plan with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits please refer to the "Government Coverage" portion of this "General Provisions" section.)

   2. **"Plan" does not include** nongroup coverage of any type, amounts of Hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Each contract for coverage under (1) and (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan**--The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense**--This concept means a Health Care Service or expense, including Deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

The following are examples of expenses or services that are **not Allowable Expenses**:

1. If a Member is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

Exception(s):

If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.
5. The amount a benefit is reduced by the Primary Plan because of a Member does not comply with the Plan provisions is not an Allowable Expense.

   Examples of these provisions are second surgical opinions, Prior Authorization of admissions and preferred provider arrangements.

D. **Claim Determination Period**--This is the Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

E. **Closed Panel Plan**--This is a Plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**--This is a parent who has been awarded custody of a child by a court decree. In the absence of a court decree, it is the parent with whom the child resided more than half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among

Health Net and other applicable group health Plans by establishing which Plan is primary, secondary and so on.

A. **Primary or Secondary Plan**--The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. **No COB Provision**--A Plan that does not contain a coordination of benefits provision is always primary.

   There is one exception: coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. **Secondary Plan Performs COB**--A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. **Order of Payment Rules**--The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

   1. **Subscriber (Non-Dependent) vs. Dependent**--The Plan that covers the person other than as a Dependent, for example as an employee, Subscriber or retiree, is primary, and the Plan that covers the person as a Dependent is secondary.

   2. **Child Covered by More Than One Plan**--The order of payment when a child is covered by more than one Plan is:
      a. **Birthday Rule**--The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
         - The parents are married;
         - The parents are not separated (whether or not they ever have been married);
         - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage; or
         - If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      b. **Court Ordered Responsible Parent**--If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination periods or plan years commencing after the Plan is given notice of the court decree.

      c. **Parents Not Married, Divorced or Separated**--If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
         - The Plan of the Custodial Parent.
         - The Plan of the spouse of the Custodial Parent.
         - The Plan of the non-Custodial Parent.
         - The Plan of the spouse of the non-Custodial Parent.

3. **Active vs. Inactive Employee**--The Plan that covers a person as an employee who is neither laid off nor retired (or their Dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or their Dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

   If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working spouse will be determined under the rule labeled D (1) above.

4. **COBRA Continuation Coverage**--If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage**--If the preceding rules do not determine the order or payment, the Plan that covers the Subscriber (non-Dependent), retiree or Dependent of either for the longer period is primary.
   a. **Two Plans Treated as One**--To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the Member was eligible under the second within twenty-four hours after the first ended.

   b. **New Plan Does Not Include**--The start of a new Plan does not include:
      i. A change in the amount or scope of a Plan's benefits.

      ii. A change in the entity that pays, provides or administers the Plan's benefits.

      iii. A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).

   c. **Measurement of Time Covered**--The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a Group Plan, the date the person first became a Member of the Group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

6. **Equal Sharing**--If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on the Benefits of This Plan

A. **Secondary Plan Reduces Benefits**--When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination period are not more than 100% of total Allowable Expenses.

B. **Coverage by Two Closed Panel Plans**--If a Member is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a nonpanel provider, benefits are not covered by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

But, if services received from a nonpanel provider are due to an emergency and would be covered by both Plans, then both Plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

Health Net may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

Health Net need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give Health Net any facts it needs to apply those rules and determine benefits payable.

Health Net's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the Member.

"Amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Government Coverage

Medicare Coordination of Benefits (COB)

When you reach age 65, you may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or End-Stage Renal Disease (ESRD). We will solely determine whether we are the Primary Plan or the Secondary Plan with regard to services to a Member enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If you are enrolled in Medicare Parts A and Part B, and are not an active employee or your employer group has less than twenty employees, then this Plan will coordinate with Medicare and be the secondary Plan. This Plan also coordinates with Medicare if you are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If you are not

enrolled in Medicare Part A and Part B, Health Net will provide coverage for Medically Necessary covered services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this Plan for the covered services described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net as required under this *Evidence of Coverage*.

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare coordination of benefits, unless you are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or
- Write to:

  Medicare Publications
  Department of Health and Human Services
  Centers for Medicare and Medicaid Services
  6325 Security Blvd.
  Baltimore, MD 21207

Medi-Cal

Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration

Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers' Compensation

This Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers' Compensation laws.

If you require covered services or supplies, and the injury or illness is work-related and benefits are available as a requirement of any Workers' Compensation or Occupational Disease Law, your Physician Group will provide services, and Health Net will then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of contracting Physician Groups. Your Physician Group performs or authorizes all care, and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency Care or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com to obtain claim forms.

If you need to file a claim for medical or Mental Health or Substance Use Disorder emergency services or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

If you need to file a claim for outpatient Prescription Drugs, please send a completed Prescription Drug claim form to:

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

Please call Health Net Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com to obtain a Prescription Drug claim form.

If you receive emergency pediatric dental services, you will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. For more information regarding claims for covered pediatric dental services, you may call Customer Service at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130

To be reimbursed for emergency pediatric dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, Member ID number, address and telephone number on all requests for reimbursement.

If you need to file a claim for covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with ASH Plans within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Acupuncture Services you may call ASH Plans at **1-800-678-9133** or you may write ASH Plans at the address given immediately above.

Payment of Claim

Within 30 calendar days of receipt of a claim (refer to "Notice of Claim" above), Health Net shall pay the benefits available under this *Evidence of Coverage* or provide written notice regarding additional information needed to determine our responsibility for the claim.

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care Plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or explanation of benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

Circumstances beyond Health Net's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant contracting Physician Group personnel or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgently Needed Care" section under the "Introduction to Health Net" section.

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. The *Evidence of Coverage*, however, will be posted electronically on Health Net's website at www.healthnet.com. The Group can opt for the Subscribers to receive the *Evidence of Coverage* online. By registering and logging on to Health Net's website, Subscribers can access, download and print the *Evidence of Coverage*, or can choose to receive it by U.S. mail, in which case Health Net will mail the *Evidence of Coverage* to each Subscriber's address on record.

If the Subscriber or the Group is required to provide notice, the notice should be mailed to the Health Net office at the address listed on the back cover of this *Evidence of Coverage*.

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **Effective: 08.14.2017**

Covered Entities Duties:

Health Net* (referred to as "we" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in effect and notify you in the event of a breach of your unsecured PHI. PHI is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the following:

- Uses or disclosures;
- Your rights;
- Our legal duties; or
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website and in our Member Handbook.

*This Notice of Privacy Practices applies to enrollees in any of the following Health Net entities: Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We are also committed in keeping your race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and social needs information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a Physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the Health Care Services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
    - Processing claims;
    - Determining eligibility or coverage for claims;
    - Issuing premium billings;
    - Reviewing services for Medical Necessity; and for
    - Performing utilization review of claims.

Health Care Operations - We may use and disclose your PHI to perform our health care operations. These activities may include:

- Providing customer services;
- Responding to complaints and appeals;
- Providing case management and care coordination;
- Conducting medical review of claims and other quality assessment; and
- Improvement activities.

In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to

another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:

- Quality assessment and improvement activities;
- Reviewing the competence or qualifications of health care professionals;
- Case management and care coordination; and
- Detecting or preventing health care fraud and abuse.

Your race, ethnicity, language, sexual orientation, and gender identity, and social needs information are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with California regulatory agencies, healthcare providers, and healthcare oversight entities. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:

- Better understand your health care needs;
- Know your language preference when seeing health care providers;
- Providing health care information to meet your care needs; and
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

Group Health Plan/Plan Sponsor Disclosures - We may disclose your protected health information to a sponsor of the Group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** - We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court;
  - Administrative tribunal;
  - Subpoena;
  - Summons;
  - Warrant;
  - Discovery request; or
  - Similar legal request.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order;
  - Court-ordered warrant;
  - Subpoena;
  - Summons issued by a judicial officer; or
  - Grand jury subpoena.

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Substance Use Disorder Records (SUD)*** - We will not use or disclose your SUD records in legal proceedings against you unless:
  - We receive your written consent; or
  - We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** - We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - Cadaveric organs;
  - Eyes; and
  - Tissues.
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - To authorized federal officials for national security and intelligence activities;
  - The Department of State for medical suitability determinations; and
  - For protective services of the President or other authorized persons.
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** - We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a Family Member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI - We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing - We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes - We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Impermissible Use of PHI - We will not use your language, race, ethnic background, sexual orientation, gender identity, and social needs information to deny coverage, services, benefits, or for underwriting purposes.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

The state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net, LLC) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose Medical Information related to Sensitive Services provided to a Protected Individual to the Group, Subscriber, or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care. Refer to the customer service phone number on the back of your Member identification card or the Plan’s website for instructions on how to request confidential communication.

- ***Right to Access and Receive Copy of Your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend Your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information, you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision, and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- **Right to Receive a Copy of this Notice** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our website or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer
c/o Office of Legal Services
California Department of Health Care Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Phone: **1-916-445-4646** or **1-866-866-0602** (TTY:TDD: 1-877-735-2929)
E-mail: Privacyofficer@dhcs.ca.gov

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, Medical Information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security:

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice:

If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

Health Net, LLC
Attn: Privacy Official
21281 Burbank Blvd
Woodland Hills, CA 91367

Please **call the toll-free phone number on the back of your ID card** or contact Health Net at **1-800-522-0088**.

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by ASH Plan to be Medically Necessary for the treatment of that condition. Acupuncture Services are typically provided only for the treatment of Nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain.

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the Acute Condition.

American Specialty Health Plans of California, Inc. (ASH Plans) is a specialized health care service Plan contracting with Health Net to arrange the delivery of Acupuncture Services through a network of Contracted Acupuncturist.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third-party national database used by Health Net.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Acupuncture Services to Members.

Copayment is a fee charged to you for covered services when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each covered service is shown in the "Schedule of Benefits and Copayments" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and

- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of nonemergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services, or the ongoing care provided by a Physician.

CVS MinuteClinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the state of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

Deductible is a set amount you pay each Calendar Year for specified covered expenses before Health Net pays any benefits for those covered expenses.

Dependent includes:

- The Subscriber's lawful spouse, as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined below.)
- The children of the Subscriber or their spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).

Domestic Partner is, for the purposes of this *Evidence of Coverage*, the Subscriber's partner if the Subscriber and partner are a couple who are registered domestic partners that meet all the requirements of Sections 297 or 299.2 of the California Family Code.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a drug manufacturer to discount the Copayment or your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum.)

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the Plan.

Emergency Care includes medical screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of their license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care,

treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

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 their license and privileges) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, either within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute Hospital or to an acute psychiatric Hospital as Medically Necessary.

Emergency Care includes air and ground ambulance and ambulance transport services provided through the "**911**" emergency response system.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an independent medical review of a Plan denial of coverage for Emergency Care.

Emergency Dental Care includes Medically Necessary services required for: (1) the alleviation of severe Pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions. However, payment for Emergency Dental Care rendered will be conditioned on Health Net's subsequent review and determination as to consistency with professionally recognized standards of dental practice and Health Net's dental policies.

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

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

Active labor is considered an Emergency Medical Condition. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Member or unborn child.

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act) that must be covered by all health benefits plans starting in 2014. Categories include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, Mental Health and Substance Use Disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Essential Drug List (also known as **Health Net Essential Drug List, Formulary** or **the List**) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com. Some Drugs in the Essential Drug List require Prior Authorization from Health Net in order to be covered.

Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions" section, as well as the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for additional information.

With regard to Acupuncture Services, "Experimental" services are acupuncture care that is an unproven Chiropractic Service or Acupuncture Service and does not meet professionally recognized, valid, evidence-based standards of practice.

Eyeglasses are the combination of Lenses and Frames worn to correct or improve vision.

Eyewear is either Eyeglasses or contact Lenses.

Family Members are Dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third-party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a health care provider by the state of California to perform the services, acting within the scope of their license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Essential Drug List (also known as **Essential Drug List** or **the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com. Some Drugs in the Essential Drug List require Prior Authorization from Health Net in order to be covered.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members and provide benefits through approved health plans.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in their place of residence that is prescribed by the Member's attending Physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this Plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility means a condition or status characterized by any of the following:

1. A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in item 3 below.
2. A person's inability to reproduce either as an individual or with their partner without medical intervention.
3. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net will decide whether a service or supply is Investigational.

With regard to Acupuncture Services, "Investigational" services are acupuncture care that is investigatory.

Lenses are single vision, bifocal or trifocal prescription Lenses that correct or improve vision.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary (or Medical Necessity)
For services other than Mental Health or Substance Use Disorders: means Health Care Services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

With regard to Acupuncture Services, "Medically Necessary" services are Acupuncture Services, which are necessary, appropriate, safe, effective and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

For Treatment of Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- "Health care provider" means any of the following:
  - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
  - An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
  - A Qualified Autism Service Provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
  - An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
  - An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
  - A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
  - A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
  - A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Subscriber or an enrolled Family Member.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group.

Mental Health and Substance Use Disorders means a Mental Health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*. Changes in

terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* or the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a Mental Health or Substance Use Disorder by health care providers practicing in relevant clinical specialties.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide, and make decisions about, health care.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible Dependents. Enrolled Members can also change Physician Groups at this time.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Health Net.

Optometrist is a licensed Doctor of Optometry (O.D.).

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for covered services for each Calendar Year. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in the "Out-of-Pocket Maximum" section.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net, to provide Mental Health and Substance Use Disorder benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or substance use disorder rehabilitation services.

Participating Dentist is a dentist or dental facility licensed to provide benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Dentists are set forth in Health Net's *Participating Dentist Directory*. The names of Participating Dentists and their locations and hours of practice may also be obtained by contacting Health Net's Customer Service Department. This Plan does not guarantee the initial or continued availability of any particular Participating Dentist.

Participating Mental Health Professional is a Physician or other professional who is licensed, certified or otherwise authorized by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health and Substance Use Disorder rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Participating Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish such care to Members.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Participating Vision Provider is an Optometrist, ophthalmologist or optician licensed to provide covered services and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's *Participating Vision Provider Directory*. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center or by contacting us at www.healthnet.com.

Physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by the Group and described in the Group Service Agreement and this *Evidence of Coverage*.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order, or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in the "Schedule of Benefits and Copayments" section, and the "Covered Services and Supplies" section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health.
- Prevent or lower the risk of diseases or illnesses.
- Detect disease or illness in early stages before symptoms develop.
- Monitor the physical and mental development in children.

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

Primary Dentist is any Participating Dentist who has the responsibility for providing benefits to Members, maintaining the continuity of patient care, initiating referral for orthodontic care and who is listed in the current *Participating Dentist Directory* for your area as a Primary Dentist.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements not otherwise specified in this document, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" portion of "Covered Services and Supplies" for details regarding the Prior Authorization process relating to Prescription Drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a noninstitutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Protected Individual means any adult covered by the Subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A health care service plan shall not require a Protected Individual to obtain the Group, Subscriber, or other enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the Protected Individual has the right to consent to care.

Psychiatric Emergency Medical Condition means a Mental Health or Substance Use Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntarily or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-

Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code):

- An immediate danger to themself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Health or Substance Use Disorder.

Qualified Autism Service Provider means either of the following: (1) A person, who is certified by a national entity, such as the Behavior Analyst Certification Board with a certification, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, who is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional:
  A. Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;
  B. Is supervised by a Qualified Autism Service Provider;
  C. Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; and
  D. Is either of the following:
     i. Is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; or
     ii. A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology;
  E. Is either of the following:
     i. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; or
     ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional;

F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a Telehealth Service provider that is contracted with Health Net to provide Telehealth Services that are covered under the "Telehealth Consultations Through the Select Telehealth Services Provider" heading as shown in the "Schedule of Benefits and Copayments" and "Covered Services and Supplies" sections. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Sensitive Services means all Health Care Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929, 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this *Evidence of Coverage*. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of their family who meet the eligibility requirements of the Group and Health Net.

Substance Use Disorder Care Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is licensed to provide substance use disorder detoxification services or rehabilitation services.

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Teledentistry can include patient care and education. See the definition of "Telehealth Services" below.

Telehealth Services means the mode of delivering Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

For the purposes of this definition, the following apply:

- "Asynchronous store and forward" means the transmission of a patient's Medical Information from an originating site to the health care provider for telehealth at a distant site without the presence of the patient.
- "Distant site" means a site where a health care provider for telehealth who provides Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Health Care Services are provided via telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a health care provider for telehealth located at a distant site.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a Terminal Illness.

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs.

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for

self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

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

LANGUAGE ASSISTANCE SERVICES

Health Net provides free language assistance services, such as in-person interpretation, telephone interpretation, video remote interpretation, sign language interpretation, translated written materials, oral translations, and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual/multilingual staff and interpreter services for additional languages to support Member language needs. Interpretation services in your language can be used for, but not limited to, explaining benefits, filing a grievance and answering questions related to your health Plan. Also, our Customer Contact Center staff can help you find a health care provider who speaks your language. Call the Customer Contact Center number on your Health Net ID card for this free service and to schedule an interpreter. Providers may not request that you bring your own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a covered benefit or service is accessed. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for Health Care Services in such a manner that ensures the provision of interpreter services at the time of the appointment. Some types of interpretation must be scheduled before the appointment.

NOTICE OF LANGUAGE SERVICES

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

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

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

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

Vietnamese

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

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

NONDISCRIMINATION NOTICE

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

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

If you need these services, contact the Health Net Customer Contact Center at
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call one of the phone numbers above or write to:

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

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

Electronically: Send an email to SM_Section1557Coord@centene.com This notice is available at Health Net website: https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

Contact us

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

Customer Contact Center
Large Group:
1-800-522-0088 TTY: 711
(for companies with 101 or more employees)

Small Group:
1-800-522-0088 TTY: 711
(for companies with 2-100 employees)

Individual & Family Plans:
1-800-839-2172 TTY: 711

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

www.healthnet.com

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