EVIDENCE OF COVERAGE AND PLAN DOCUMENT

A complete explanation of your Plan

Gold PPO 1500/20

Important benefit information – please read

1/2026 SG PPO

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 choose to 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 pays Participating Providers on a fee-for-service basis, according to an agreed Contracted Rate. 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.

Use of Special Words

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

In addition, 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.
- **"Group"** is the business entity (usually an employer) that contracts with Health Net to provide this coverage to you.
- **"Plan" and "*Evidence of Coverage* (EOC)"** have similar meanings. You may think of these as meaning your Health Net benefits.
- **"Preferred Provider Organization Plan" or "PPO"** means a Preferred Provider Organization (PPO) plan. In a PPO plan, you have the flexibility to choose the providers you see. You can receive care from In-Network Providers or Out-of-Network Providers.
- **"Preferred Provider," "Participating Physician," or "In-Network Provider"** means the provider who has agreed to participate in Health Net's Preferred Provider Organization ("PPO") to provide covered services and supplies, as explained in this *EOC*, and accept a special Contracted Rate, called the Contracted Rate, as payment in full. Your share of costs is based on this Contracted Rate.
- **"Out-of-Network Provider," or "Non-Participating Providers"** means the provider who is not part of the Health Net's Preferred Provider Organization Network ("PPO Network"). Out-of-Network Providers do not have a contract with Health Net to accept Health Net's Maximum Allowable Amount (MAA) as payment in full for covered services and supplies. Except for Emergency Care (and services received at a Participating Hospital under certain conditions), you will pay more for covered services from an Out-of-Network Provider.
- **"Tier" or "Level"** refers to a benefit option offered in your Health Net PPO Plan benefits.
- **"In-Network Tier," or "In-Network Benefit Level"** refers to the benefit option in which you receive covered services and supplies from Preferred Providers.
- **"Out-of-Network Tier" or "Out-of-Network Benefit Level"** refers to the benefit option in which you receive covered services and supplies from Out-of-Network Providers.
- **"Cost Sharing"** refers to your share of costs for covered services and supplies under this Plan. This term includes Deductibles, Coinsurance, and Copayments which are determined from Covered Expenses. You are responsible for any charges that are not Covered Expenses.

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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.

Welcome to the Preferred Provider Organization ("PPO") Plan, a product of Health Net, a health care service plan regulated by the California Department of Managed Health Care. Health Net PPO provides two (2) coverage options: the flexibility of a Preferred Provider Organization network ("PPO Network") through the in-network benefit level and the traditional indemnity arrangement through the out-of-network benefit level.

This Plan covers care from in-network providers and Out-of-Network Providers. You do not need a referral. However, some services do require Prior Authorization (or treatment review). This *Evidence of Coverage* (*EOC*) will explain the benefits that are available to you under this Plan.

IMPORTANT NOTE: WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. This is because the cost sharing for the out-of-network benefit is typically higher than for the in-network benefit. Plus, you are responsible for the difference between the amount the Out-of-Network Provider bills and the Maximum Allowable Amount (MAA). See "Your Financial Responsibility" later in this section for more details.

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.

Please read this entire *Evidence of Coverage* so you will understand how your benefits work.

How to Obtain Care – In-Network

Under the in-network benefit level, you receive medical care from a Preferred Provider listed in the *Health Net PPO Network Directory*. Simply call the Preferred Provider to schedule an appointment. Refer to "Timely Access to Care – Preferred Providers" later in this section for more details about scheduling an appointment with Preferred Providers.

To receive care related to Mental Health and Substance Use Disorders from a Preferred Provider, contact Health Net by calling the phone number as shown on your Health Net ID card. Health Net will help you identify a nearby Participating Mental Health Professional and with whom you can schedule an appointment.

To obtain a copy of the *Health Net PPO Network Directory*, please 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. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more.

Preferred Providers have agreed to accept the Contracted Rate as payment in full. Your share of cost is based on the Contracted Rate. When you use a Health Net Preferred Provider, you are not responsible for any amounts billed in excess of the Contracted Rate.

The PPO Network is subject to change. It is your obligation to be sure that the provider you choose is a Preferred Provider with a Health Net agreement in effect. IMPORTANT NOTE: Please be aware that it is your responsibility and in your best financial interest to verify that the health care providers treating you are Preferred Providers, including:

- The Hospital or other facility where care will be given. After verifying that the Hospital or the facility is a Preferred Provider, you should not assume all providers at that Hospital or facility are also Preferred Providers; if you receive services from an Out-of-Network Provider at that Hospital or facility, refer to "How to Obtain Care – Out-of-Network" below for information on how those services are paid.
- The provider you select, or to whom you are referred, are a Preferred Provider at the specific location at which you will receive care. Some providers participate at one location, but not at others.

Preferred Providers may refer Members to Out-of-Network Providers. If you receive care from an Out-of-Network Provider, even if the referral to that provider is from a Preferred Provider, then services are covered at the out-of-network benefit level. **It is your obligation to confirm if the provider, to whom you are referred, is a Preferred Provider or an Out-of-Network Provider. To verify if the provider is a Preferred Provider, check the *Health Net PPO Network Directory*, 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. You are responsible for the cost share of the benefit level (that is, Preferred Provider or Out-of-Network Provider) that applies to the provider.**

Some of the Covered Expenses under the in-network benefit level are subject to a requirement of Prior Authorization, or treatment review, in order for full benefits to be available to you. Please refer to the "Prior Authorization Requirement" section in this *Evidence of Coverage* for additional information.

Specialists and Referral Care

In the event that you desire to see a Specialist, find the Specialist you wish to see in the *Health Net PPO Network Directory* and schedule an appointment.

Covered Services That Are Not Available Through a Preferred Provider

Health Net may authorize covered services from an out-of-network Specialist or ancillary provider when the Member cannot obtain Medically Necessary care from a Preferred Provider because either: (1) Health Net does not have the provider type in its network; or (2) Health Net does not contract with the

provider type within a reasonable distance from the Member's residence and an Out-of-Network Provider of that type is within such reasonable distance. When Health Net authorizes such care, covered services from the Out-of-Network Provider will be paid at the in-network level of benefit. The Member will pay the cost sharing as shown under the "Preferred Provider" tier in the "Schedule of Benefits" section of this *EOC*.

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.

How to Obtain Care – Out-of-Network

Under the out-of-network benefit level, you may receive medical care from any licensed Out-of-Network Provider. Out-of-Network Providers have not agreed to participate in the Health Net PPO Network. Therefore, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage* for more details on how we determine MAA.

Some of the Covered Expenses under the out-of-network benefit level are subject to a requirement of Prior Authorization, or treatment review, in order for full benefits to be available to you. Please refer to the "Prior Authorization Requirement" section in this *Evidence of Coverage* for additional information.

Specialists and Referral Care

In the event you desire to see a particular Specialist that is not listed in the Health Net PPO Network *Directory*, you can obtain services from an out-of-network Physician. Simply schedule an appointment with the provider. Services will be reimbursed to you based on the Maximum Allowable Amount and your benefits once you submit the claims to Health Net.

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.

Your Financial Responsibility

Preferred Providers

Covered services or supplies from Preferred Providers are paid at the in-network benefit level. The maximum amount of Covered Expenses for a service or supply provided by a Preferred Provider is the lesser of the billed charge or the Contracted Rate. You will not be responsible for any amount billed in excess of the Contracted Rate. However, you are responsible for any applicable Deductible, Copayments or Coinsurance payment. You are always responsible for services or supplies not covered by this Plan.

Out-of-Network Providers

Covered services or supplies from Out-of-Network Providers are paid at the out-of-network benefit level. Your share of cost is based on the Maximum Allowable Amount. For more information on how we determine the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage.* You are responsible for any applicable Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of the Maximum Allowable Amount. THEREFORE, WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.

You are completely financially responsible for care that this Plan does not cover. Additionally, the Out-of-Network Provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net for a determination of what portion of the billed charges is reimbursable to you.

Covered Services from an Out-of-Network Provider at an In-Network Facility

When Nonemergent Services are provided by an Out-of-Network Provider: Nonemergent services provided by an Out-of-Network Provider at a Preferred Provider facility will be payable at the in-network benefit level, with the same cost sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount); the cost sharing and Deductible will accrue to the in-network Out-of-Pocket Maximum.

However, the Out-of-Network Provider may bill or collect from you the difference between a provider's billed charge and the Maximum Allowable Amount in addition to any applicable out-of-network Deductible(s), Copayments and/or Coinsurance, only when you consent in writing at least 24 hours in advance of care. In order to be valid, that consent must meet all of the following requirements: (1) it must be in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, (2) the Out-of-Network Provider has given you a written estimate of the total out-of-pocket cost of care, (3) the consent has advised you that you may elect to seek care from a Preferred Provider or may contact Health Net to arrange to receive care from a Preferred Provider, (4) that any costs that you incur as a result of your use of the out-of-network benefit level shall be in addition to the in-network cost-sharing amounts and may not count toward the in-network annual Out-of-Pocket Maximum or an in-network Deductible, if any, and (5) the consent and estimate shall be provided to you in languages other than English under certain circumstances.

For information regarding Health Net's payment for out-of-network nonemergent services, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*.

When Emergency Services are provided by an Out-of-Network Provider: When covered services are received in connection with Emergency Care, you will pay the Preferred Provider level of cost sharing, regardless of whether the provider is a Preferred Provider or an Out-of-Network Provider, and without balance billing. Balance billing is the difference between an Out-of-Network Provider's billed charge and the Maximum Allowable Amount. When you receive Emergency Care from an Out-of-Network Provider, your payment of the cost sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for Preferred Providers.

For information regarding Health Net's payment for out-of-network Emergency Care, please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*.

Deductible

For certain services and supplies under this Plan, a Deductible may apply which must be satisfied before these services and supplies are payable by Health Net. Such services and supplies are only covered to the extent that Covered Expenses exceed the Deductible. You will be notified by us of your Deductible accumulation for each month in which benefits were used. You will also be notified when you have reached your Deductible amount for the Calendar Year. You can also obtain an update on your Deductible accumulation by calling the Customer Contact Center at the telephone number on your ID card. Refer to the "Schedule of Benefits" section for specific information on Deductible(s).

Nonauthorization Penalties

Some Covered Expenses under this Plan require Prior Authorization. Nonauthorization penalties apply to covered services or supplies that require Prior Authorization but Prior Authorization is not obtained. Refer to the "Schedule of Benefits" and "Prior Authorization Requirement" sections for specific information.

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.

Questions

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

Timely Access to Care – Preferred Providers

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. Health Net's in-network providers agree to provide timely access to care.

Please contact Health Net at the number shown on your Health Net ID card, 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 an In-Network Physician

When you need to see your Physician, 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 a Participating Provider. Wait times depend on your condition and the type of care you need. You should get an appointment to see a Participating Provider.

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

Your Participating 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 does not require Prior Authorization: within 48 hours of request**
- **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**
- **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 an In-Network Specialist for Medical and Surgical Services

When you need to see a Specialist, call their office for an appointment. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net PPO 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 In-Network 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 service, 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.

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 your 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.

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, at the in-network benefit level. You must request the coverage within 60 days of your Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the Group's effective date and you make the request as soon as reasonably possible. The Out-of-Network 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 at the in-network benefit level.

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.

Emergency and Urgently Needed Care through Your PPO Plan

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 Physician 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.**

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.

Emergency Care is covered and does not require Prior Authorization. Emergency Care is covered at the in-network benefit level regardless of whether the services are performed by a Preferred Provider or an Out-of-Network Provider.

Urgently Needed Care is covered and does not require Prior Authorization. Urgently Needed Care is covered at the benefit level that applies to the provider of service. Always present your Health Net PPO 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.

After your medical problem (including Mental Health and Substance Use Disorder) 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 performed by an Out-of-Network Provider are covered as described earlier in this section under "How to Obtain Care – Out-of-Network."*

Follow-Up Care after Emergency Care at a Hospital: 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 Hospital must contact Health Net to obtain timely Prior Authorization or you will be subject to the nonauthorization penalty. If you want to be transferred from an Out-of-Network Hospital to a Preferred Provider Hospital, and Health Net determines that you may be safely transferred, Health Net will arrange for the transfer and for the care to continue at the Preferred Provider Hospital

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 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 Deductible and Copayment or Coinsurance shown in the "Schedule of Benefits" section. You may have to pay for the Prescription Drug when it is dispensed.

To be reimbursed, you must file a claim with Health Net. Call our 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:

The "Prescription Drugs" portion of the "Exclusions and Limitations" section and the requirements of the Essential Drug List also applies.

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.

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.

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SCHEDULE OF BENEFITS

The following schedule shows the applicable Deductible(s), Copayments or Coinsurance for covered services and supplies under this Plan. There is a limit to the amount of Copayments or Coinsurance you must pay in a Calendar Year. Refer to the "Out-of-Pocket Maximum" section for more information.

In-Network: When you receive care or services from a Preferred Provider, you will be responsible for the applicable Deductible(s), Copayments, or a percentage of the Contracted Rate (Coinsurance) as stated after each benefit listed below under the heading "Preferred Provider."

Out-of-Network: Except for Emergency Care, when you receive care or services from an Out-of-Network Provider, you will be responsible for the applicable Deductible(s), Copayments, or a percentage of the Maximum Allowable Amount (Coinsurance) as stated after each benefit listed below under the heading "Out-of-Network Provider." (There are additional exceptions as stated in the "Introduction to Health Net" section.) *You will also be responsible for any charges the Out-of-Network Provider bills in excess of the Maximum Allowable Amount.* For more details about the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage.*

Some covered services and supplies require Prior Authorization or your benefits will be reduced as shown under "Nonauthorization Penalties" in this schedule. Please see the "Prior Authorization Requirement" section for further details.

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. Telehealth Services will be covered only when performed by a Preferred Provider. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

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

Calendar Year Deductible

Each Calendar Year, you must meet the Deductible amount below before Covered Expenses for medical services or supplies can be paid by Health Net. Certain services are not subject to the Calendar Year Deductible and are indicated as "Deductible waived" or "Calendar Year Deductible waived" in this "Schedule of Benefits" section. The Calendar Year Deductible does not apply to Preventive Care Services through Preferred Providers.

	Preferred Provider	Out-of-Network Provider
Calendar Year Deductible, per Member	$1,500	$3,000
Calendar Year Deductible, per family (all enrolled members of a family)	$3,000	$6,000

Note(s):

Once the family Deductible is met, no further Calendar Year Deductible is required for any member of the family during the remainder of that Calendar Year.

Any amount applied toward the Calendar Year Deductible for covered services and supplies received from a Preferred Provider will **not** apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for covered services and supplies received from an Out-of-Network Provider will not apply toward the Calendar Year Deductible for Preferred Providers.

Only Covered Expenses will be applied to the satisfaction of the Calendar Year Deductible. The following does not apply to the Calendar Year Deductible:

- Any nonauthorization penalties incurred by you for receiving nonauthorized services,
- Expenses incurred under the Prescription Drug benefit.

Nonauthorization Penalties

Some Covered Expenses require Prior Authorization. Nonauthorization penalties apply to covered services or supplies that require Prior Authorization but Prior Authorization is not obtained. For a list of services which require Prior Authorization, please see the "Prior Authorization Requirement" section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

	Preferred Provider	Out-of-Network Provider
Medically Necessary services for which Prior Authorization was required but not obtained	$250	$500

Note(s):

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.

The nonauthorization penalty listed above will apply before the Coinsurance or Copayment is applied to the nonauthorized service. The nonauthorization penalty will not exceed the cost of the benefit to Health Net.

For a list of services which require Prior Authorization, please see the "Prior Authorization Requirement" section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

Copayments and Coinsurance

After you meet the Calendar Year Deductible amount described above, you remain responsible for paying the applicable additional benefit Deductibles, Copayments or Coinsurance described below until you satisfy the Out-of-Pocket Maximum. Certain benefits are not subject to the Calendar Year Deductible and are indicated as "Deductible waived" or "Calendar Year Deductible waived" in this "Schedule of Benefits" section.

UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED SERVICES AND SUPPLIES PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.

Services obtained in an Emergency Room or Urgent Care Center (Medical care other than Mental Health and Substance Use Disorder services)

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Use of emergency room facility	30%	30%
Emergency room professional services	30%	30%
Use of urgent care center (facility and professional services)	$20 (Deductible waived)	50%

Note(s):

* The cost-sharing amounts shown for Out-of-Network Providers will only apply to services that do not meet the criteria of Emergency Care as defined in the "Definitions" section of this *Evidence of Coverage.* Emergency Care is covered under your Preferred Provider level of benefits even when such services are from an Out-of-Network Provider and will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount). For information regarding Health Net's payment for out-of-network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of the *Evidence of Coverage.*

Refer to "Ambulance Services" below for emergency medical transportation Copayment or Coinsurance.

Services obtained in an Emergency Room or Urgent Care Center (Mental Health and Substance Use Disorder services)

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Use of emergency room facility	30%	30%
Emergency room professional services	30%	30%
Use of urgent care center (facility and professional services)	$20 (Deductible waived)	50%

Note(s):

* The cost-sharing amounts shown for Out-of-Network Providers will only apply for services that do not meet the criteria of Emergency Care as defined in the "Definitions" section of this *Evidence of Coverage.* Emergency Care is covered under your Preferred Provider level of benefits even when such services are from an Out-of-Network Provider and will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount). For information regarding Health Net's payment for out-of-network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of the *Evidence of Coverage.*

Refer to "Ambulance Services" below for emergency medical transportation Copayment or Coinsurance.

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

	Preferred Provider or Emergency Care	Out-of-Network Provider
Ground ambulance	30%	Payable at the Preferred Provider level of benefits
Air ambulance	30%	Payable at the Preferred Provider level of benefits

Note(s):

Prior Authorization for nonemergency ground or air ambulance transport is required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

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

Covered services provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Ambulance Services (Mental Health and Substance Use Disorder services)

	Preferred Provider or Emergency Care	Out-of-Network Provider
Ground ambulance	30%	Payable at the Preferred Provider level of benefits

	Preferred Provider or Emergency Care	Out-of-Network Provider
Air ambulance	30%	Payable at the Preferred Provider level of benefits

Note(s):

Prior Authorization for nonemergency ground or air ambulance transport is required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

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

Covered services provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Office Visits

	Preferred Provider	Out-of-Network Provider
Visit to Physician, Physician Assistant, Nurse Practitioner, or Podiatrist	$20 (Deductible waived)	50%
Specialist consultation	$50 (Deductible waived)	50%
Physician visit to Member's home	$20 (Deductible waived)	50%
Specialist visit to Member's home	$50 (Deductible waived)	50%
Annual physical examination*	Not covered	Not covered
Vision examination for diagnosis or treatment (ages 19 and older) by an Optometrist**	$20 (Deductible waived)	50%
Vision examination for diagnosis or treatment (ages 19 and older) by an ophthalmologist**	$50 (Deductible waived)	50%
Hearing examination for diagnosis or treatment	$20 (Deductible waived)	50%

	Preferred Provider	Out-of-Network Provider
Telehealth consultation through the Select Telehealth Services Provider***	$0 (Deductible waived)	Not covered

Note(s):

* 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.

** See "Pediatric Vision Services" for details regarding pediatric vision care services.

***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

	Preferred Provider	Out-of-Network Provider
Preventive Care Services	$0 (Deductible waived)*	50%

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 or Coinsurance for those services.

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

Hospital Visits by Physician

	Preferred Provider	Out-of-Network Provider
Physician visit to Hospital or Skilled Nursing Facility	30%	50%

Note(s):

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

Allergy, Immunizations and Injections

	Preferred Provider	Out-of-Network Provider
Allergy testing	$20 (Deductible waived)	50%
Allergy injection services (serum not included)	$20 (Deductible waived)	50%
Allergy serum	30%	50%
Immunizations for occupational purposes or foreign travel	Not covered	Not covered
Injections Office-based injectable medications - administration (per dose)*	30%	50%
Office-based injectable medications – injected substance (per dose)*	30%	50%

Note(s):

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

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 provider 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 "Prescription Drugs" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

Rehabilitation and Habilitation Therapy

	Preferred Provider	Out-of-Network Provider
Physical therapy, speech therapy, occupational therapy, habilitation therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	$20 (Deductible waived)	50%

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" portion of the "Exclusions and Limitations" section.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Care for Conditions of Pregnancy

	Preferred Provider	Out-of-Network Provider
Prenatal care and preconception visits*	$20 (Deductible waived)	50%
Postnatal office visit*	$20 (Deductible waived)	50%
Specialist consultation regarding pregnancy	$50 (Deductible waived)	50%
Newborn care office visit (birth through 30 days)*	$20 (Deductible waived)	50%
Physician visit to the mother or newborn at a Hospital	30%	50%
Normal delivery, including cesarean section	30%	50%
Circumcision of newborn (birth through 30 days)**		
In an inpatient setting	30%	50%
In a Physician's office or outpatient facility	30%	50%

Note(s):

The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance 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 under Preferred Providers and the Calendar Year Deductible does not apply. See "Preventive Care Services" above. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" in the "Covered Services and Supplies" section.

  Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

** Circumcisions for Members age 31 days or older are covered when Medically Necessary under "Outpatient Surgery." Refer to the "Outpatient Facility Services" section for applicable Copayments or Coinsurance.

Family Planning

	Preferred Provider	Out-of-Network Provider
Sterilization of female	$0 (Deductible waived)	50%
Sterilization of male	$0 (Deductible waived)	50%
Reversal of sterilization of male	Not covered	Not covered

Note(s):

The above Copayments and Coinsurances apply to professional services only. Services that are rendered by an Out-of-Network Provider in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance that may apply.

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

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

Other Professional Services

	Preferred Provider	Out-of-Network Provider
Surgery or assistance at surgery Performed in an office or outpatient facility	30%	50%
Surgery or assistance at surgery Performed in an inpatient setting	30%	50%
Administration of anesthetics Performed in an office or outpatient facility	30%	50%

	Preferred Provider	Out-of-Network Provider
Administration of anesthetics Performed in an inpatient setting	30%	50%
Chemotherapy	30%	50%
Radiation therapy	30%	50%
Laboratory services in a Physician's office or outpatient facility	$20 (Deductible waived)	50%
Laboratory services in an inpatient setting	30%	50%
Diagnostic imaging (including x-ray) services in a Physician's office or outpatient facility	$50 (Deductible waived)	50%
Diagnostic imaging (including x-ray) services in an inpatient setting	30%	50%
Complex radiology (CT, SPECT, MRI, MUGA and PET) services in a Physician's office or outpatient facility	30%	50%
Complex radiology (CT, SPECT, MRI, MUGA and PET) services in an inpatient setting	30%	50%
Medical social services	30%	50%
Patient education*	$20 (Deductible waived)	50%
Nuclear medicine (use of radioactive materials)	30%	50%
Renal dialysis	30%	50%
Organ, tissue or stem cell transplants	See note below**	See note below**
Infusion therapy in an office, outpatient or home setting	30%	50%

Note(s):

The above Copayments or Coinsurance 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 or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance 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.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

* 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 through a Preferred Provider; 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 or Coinsurance will apply.

** Applicable Deductible or Coinsurance, or 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 or Coinsurance will apply. Refer to the "Organ, Tissue and Stem Cell Transplants" portion of the "Covered Services and Supplies" section for details.

Services for bariatric surgery and organ, tissue and stem cell transplants by Out-of-Network Providers are not covered.

Medical Supplies

	Preferred Provider	Out-of-Network Provider
Durable Medical Equipment, nebulizers, including face masks and tubing*	30%	50%
Orthotics (such as bracing, supports and casts)	30%	50%
Diabetic equipment, including diabetic footwear**	30%	50%
Prostheses (internal or external)***	30%	50%
Blood or blood products except for drugs used to treat hemophilia, including blood factors	30%	50%
Drugs used to treat hemophilia, including blood factors****	30%	50%

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 or Coinsurance, you will only pay the retail charge.

* Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by a Health Net designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by Health Net as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. For information about Health Net's designated contracted vendors for Durable Medical Equipment, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

** Corrective Footwear for the management and treatment of diabetes are covered under "Diabetic Equipment" 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 "Ostomy and Urological Supplies" portion of "Covered Services and Supplies."

****Drugs for the treatment of hemophilia, including blood factors, have a Copayment and Coinsurance maximum of $250 per day when received through a Preferred Provider. They are also covered under the Prescription Drug benefit.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" if Prior Authorization is required but not obtained.

Home Health Care Services

	Preferred Provider	Out-of-Network Provider
Home health visit	30%	50%
Combined Calendar Year maximum	*100 visits*	*100 visits*

Note(s):

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Hospice Services

	Preferred Provider	Out-of-Network Provider
Hospice Care	$0 (Deductible waived)	50%

Note(s):

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Inpatient Hospital Services

	Preferred Provider	Out-of-Network Provider
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	30%	50%

Note(s):

The above cost-sharing amounts apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services cost-sharing. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional cost-sharing that may apply. Sterilization provided by a Preferred Provider at an in-network Hospital or outpatient facility are not subject to Copayments or Coinsurance.

The above cost-sharing amounts apply to 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 Deductible, Copayment or Coinsurance 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.

The Preferred Provider Deductible and Coinsurance will apply if you are admitted to a Hospital directly from an emergency room or urgent care center. You will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Services for bariatric surgery and organ, tissue and stem cell transplants by Out-of-Network Providers are not covered.

Outpatient Facility Services

	Preferred Provider	Out-of-Network Provider
Outpatient surgery (Hospital charges only)	30%	50%
Outpatient surgery (Outpatient Surgical Center charges only)	30%	50%
Outpatient services (other than surgery)	30%	50%

Note(s):

The above cost-sharing amounts 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 cost-sharing that may apply. Sterilization provided by a Preferred Provider at an in-network Hospital or outpatient facility are not subject to Copayments or Coinsurance.

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 or Coinsurance that 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 Copayment or Coinsurance payments 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 or Coinsurance applicable for outpatient facility services.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" if Prior Authorization is required but not obtained.

Skilled Nursing Facility Services

	Preferred Provider	Out-of-Network Provider
Room and board in a semi-private room with ancillary (additional) services	30%	50%

Note(s):

Prior Authorization is required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Mental Health and Substance Use Disorders

Mental Health and Substance Use Disorders

	Preferred Provider	Out-of-Network Provider
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	$20 (Deductible waived)	50%
Outpatient group therapy session	$20 (Deductible waived)	50%

	Preferred Provider	Out-of-Network Provider
Outpatient services other than office visit/professional consultation (including psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization, 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)*	30%	50%
Mental health professional visit to Member's home (at the discretion of the mental health professional)	$20 (Deductible waived)	50%
Mental health professional visit to Hospital, Behavioral Health Facility or Residential Treatment Center	30%	50%
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	30%	50%
Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center	30%	50%

Note(s):

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

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

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

Prescription Drugs

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. Also refer to Notes below for clarification regarding Deductible, Copayment, Coinsurance, and any applicable Coinsurance maximum or benefit maximums.

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.

Prescription Drug Deductible

	Participating Pharmacy	Nonparticipating Pharmacy
Prescription Drug Deductible, (per Member, per Calendar Year)	$250	Not covered
Prescription Drug Deductible, (per family*, per Calendar Year)	$500	Not covered

Note(s):

* For a family of two or more enrolled Members, you reach the Deductible either when you meet the per Member Deductible, or when your entire family reaches the family Deductible described above.

Once you have met your Prescription Drug Deductible, you are only responsible for the applicable retail pharmacy or mail order Copayment and Coinsurance, as described below, each time a covered Prescription Drug is dispensed to you.

The Prescription Drug Deductible does not apply to peak flow meters and inhaler spacers for the treatment of asthma, preventive drugs, contraceptives, or diabetic supplies and equipment dispensed through a Participating Pharmacy.

The amount applied toward your Prescription Drug Deductible for covered Prescription Drugs is the Prescription Drug Covered Expense (as defined in the "Definitions" section) or the pharmacy's cost of the prescription, whichever is less.

Copayment and Coinsurance

Retail Pharmacy (up to a 30-day supply)	Participating Pharmacy	Nonparticipating Pharmacy
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$5 (Deductible waived)	Not covered

Retail Pharmacy (up to a 30-day supply)	Participating Pharmacy	Nonparticipating Pharmacy
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	Not covered
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	$90	Not covered
Preventive drugs and contraceptives	$0 (Deductible waived)	Not covered

Tier 4 Drugs (Specialty Drugs) (up to a 30-day supply)	Specialty Pharmacy Vendor	Nonparticipating Specialty Pharmacy Vendor
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%	Not covered
Maximum amount payable by Member per prescription	*$250*	*Not applicable*

Maintenance Drugs through the Mail Order Program (up to a 90-day supply)	Mail Order Program	Nonparticipating Mail Order Program
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$10 (Deductible waived)	Not covered
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	$100	Not covered
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	$180	Not covered
Preventive drugs and contraceptives	$0 (Deductible waived)	Not covered

Note(s):

You will be charged the applicable Deductible, Copayment or Coinsurance for each Prescription Drug Order. The Coinsurance listed above is based on the Prescription Drug Covered Expense.

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.

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.

Orally administered anti-cancer drugs will have a Copayment and Coinsurance 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.

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 at the Copayment for Tier 3 Drugs or Tier 4 Drugs (Specialty Drugs). Covered Brand Name Drugs are subject to the applicable Prescription Drug Deductible as required for Brand Name Drugs and Copayment for Tier 2 Drugs, Tier 3 Drugs or Tier 4 Drugs (Specialty Drugs).

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

Prior Authorization:

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Services and Supplies" 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.

Copayment Exceptions:

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, and are not subject to the Deductible. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section for additional details. 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.

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.

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.

Mail Order:

Up to a 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance. 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 Health Net 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

	Preferred Provider	Out-of-Network Provider
New patient examination	$15 (Deductible waived)	50%
Each subsequent visit	$15 (Deductible waived)	50%
Re-examination visit	$15 (Deductible waived)	50%

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.

Note(s):

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

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

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	Participating Vision Provider
Routine eye examination with dilation	$0 Deductible waived
Examination for contact Lenses	$0 Deductible waived

Standard contact Lens fit and follow-up to $55
Premium contact Lens fit and follow-up

Limitation(s):

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

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)	Participating Vision Provider
Provider selected frames (one every 12 months)	$0 Deductible waived
Standard Eyeglass Lenses (one pair every 12 months)	$0 Deductible waived
• Single vision, bifocal, trifocal, lenticular	
• Glass or plastic, including polycarbonate	
Optional Lenses and treatments including	$0 Deductible waived
• 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 Deductible waived
• 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 Copayment, Deductible waived

Medically Necessary Contact Lenses:

Coverage of Medically Necessary contact Lenses is subject to Medical Necessity. See the "Pediatric Vision Services" portion of "Exclusions and Limitations" for details of limitations. When covered, contact Lenses are furnished at the same coverage interval as eyeglass Lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames.

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

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

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.

Refer to the "Pediatric Dental Services" portion of the "Covered Services and Supplies" and "Exclusions and Limitations" sections of this *Evidence of Coverage* for the complete listing of covered Dental Services under each dental benefit category and the benefit limitations.

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.

Dental Benefit Category	Participating Dentist (The Coinsurance is based on Eligible Dental Expenses.)	Non-Participating Dentist (The Coinsurance is based on Eligible Dental Expenses.)
Diagnostic Benefits	$0 Deductible waived	10% Deductible waived
Preventive Benefits	$0 Deductible waived	10% Deductible waived
Restorative Benefits	20% Deductible waived	30% Deductible waived
Endodontics	50% Deductible waived	50% Deductible waived
Periodontal Maintenance Services (D4910)	20% Deductible waived	30% Deductible waived
Periodontics (other than Periodontal Maintenance (D4910))	50% Deductible waived	50% Deductible waived
Maxillofacial Prosthetics	50% Deductible waived	50% Deductible waived
Implant Services	50% Deductible waived	50% Deductible waived
Prosthodontics (Removable)	50% Deductible waived	50% Deductible waived
Fixed Prosthodontics	50% Deductible waived	50% Deductible waived
Oral and Maxillofacial Surgery	50% Deductible waived	50% Deductible waived
Medically Necessary Orthodontics	50% Deductible waived	50% Deductible waived
Adjunctive Services	50% Deductible waived	50% Deductible waived

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 Deductibles, Copayment and Coinsurance 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 the medical benefits, including covered services and supplies and Prescription Drug benefits are:

	Preferred Provider	Out-of-Network Provider
Individual OOPM	$8,000	$16,000
Family OOPM	$16,000	$32,000

Exceptions to OOPM

Only Covered Expenses will be applied to OOPM. The following expenses will not be counted, nor will these expenses be paid at 100% after the OOPM is reached.

- Nonauthorization penalties paid for services which were not authorized as required.
- Out-of-pocket costs for Prescription Drugs exceeding Prescription Drug benefit coverage as described in the "Retail Pharmacies and the Mail Order Program" provision of the "Prescription Drugs" subsection of the "Covered Services and Supplies" section and any cost differential between brand/generic medications when dispensing Brand Name Drugs not based on Medical Necessity.

  You are required to continue to pay these Deductible(s), Coinsurance and Copayments listed in the bullets above after the Preferred Provider and Out-of-Network Provider OOPM has been reached. In addition, you will continue to pay any charges billed by an Out-of-Network Provider in excess of the Maximum Allowable Amount or Prescription Drug Covered Expense.

How the OOPM Works

- Any Deductible, Copayments or Coinsurance paid for the services of a Preferred Provider will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductible, Copayments or Coinsurance paid for the services of an Out-of-Network Provider will **not** apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for out-of-network Emergency Care (including emergency medical transportation, emergency Hospital care) and urgent care received outside the United States will be applied to the Out-of-Pocket Maximum for Preferred Providers.
- If an individual Member pays amounts for covered services and supplies in a Calendar Year that equal the per Member 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 or Coinsurance and Calendar Year Deductible(s) until either (a) the aggregate of such Copayments or Coinsurance and Calendar Year Deductible(s) 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 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) of a Group that is based in the Health Net PPO Service Area, as long as they live in California; 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 stat*e or federal law, are eligible.

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 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 this Plan takes effect, if the employee is eligible on that date; or
- 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 calendar 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 calendar 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.

Adopted Child: A newly adopted child or a child who is being adopted, becomes eligible on the date the appropriate legal authority grants the Subscriber or their spouse, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child before the 60th day for coverage to continue beyond the first 30 days.

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 Health Net's Customer Contact Center upon your Effective Date about the confinement.

Health Net 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 the "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 Group 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 Group 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 Group 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

We shall allow an employee, and when specified below, their Dependent, to enroll in or change health benefit plans as a result of the following triggering events:

- An employee or their Dependent loses minimum essential coverage for any other reason except failure to pay premiums or when the coverage is rescinded for fraud or intentional misrepresentation of material fact.
- 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 employee or enrollee or their Dependent has been released from incarceration.
- 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 contracts 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, registration of domestic partnership, or assumption of a parent-child relationship 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 or placement for adoption, you can enroll yourself and the Dependent within 60 days of childbirth, marriage, 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: 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 Group 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 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.

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

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 continental United States, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred.
- 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 any applicable the Deductible,

Coinsurance 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 California, 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 California.
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 date your 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 qualifying 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:

- Is enrolled in Medicare;
- 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.

  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;
- Is covered or could become covered by any federal laws regarding continuation of group health plan coverage;
- 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;” or
- 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 Deductible, Copayments and Coinsurance payments shown in the "Schedule of Benefits" 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 the "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 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 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.

PRIOR AUTHORIZATION REQUIREMENT

Some of the Covered Expenses under this Plan are subject to a requirement of Prior Authorization, or treatment review, before services are received, in order for the nonauthorization penalty to not apply.

Prior Authorizations are performed by Health Net or an authorized designee. The telephone number which you can use to obtain Prior Authorization is listed on your Health Net ID card. If you are outside California, require medical care or treatment, and use a provider from the supplemental network, Prior Authorizations will be performed by the supplemental network. For additional information, see "Out-of-State Providers" in the "Miscellaneous Provisions" section. For additional information regarding Prior Authorization requirements for Mental Health and Substance Use Disorders, see the "Mental Health and Substance Use Disorders" portion of "Covered Services and Supplies."

Services provided as the result of an emergency are covered at the in-network benefit level and do not require Prior Authorization.

We may revise the Prior Authorization list from time to time. Any such changes including additions and deletions from the Prior Authorization list will be communicated to Participating Providers and posted on the www.healthnet.com website.

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.

Services Requiring Prior Authorization

Inpatient admissions

Any type of facility, including, but not limited to:

- Acute rehabilitation center
- Behavioral health facility
- Hospice
- Hospital
- Skilled Nursing Facility
- Substance abuse facility

Outpatient procedures, services or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
- Acupuncture (after the initial consultation)
- Ambulance: nonemergency, air or ground ambulance services
- Bariatric procedures
- Bronchial thermoplasty
- Capsule endoscopy

- Cardiovascular procedures
- Clinical trials
- Diagnostic procedures including:
  1. Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
  2. Cardiac imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Myocardial Perfusion Imaging (MPI)
     - Multigated Acquisition (MUGA) scan
  3. Sleep studies (facility-based sleep testing)
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) services
- Enhanced External Counterpulsation (EECP)
- Experimental or Investigational services and new technologies
- Gender affirming services
- Genetic testing (Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer)
- Interventional Pain Management
  - Facet joint denervation, injection or block
  - Epidural spine injections
  - Sacroiliac (SI) joint injection
  - Spinal cord stimulator
  - Sympathetic nerve block
- Mental Health and Substance Use Disorder services other than office visits including:
  1. Applied Behavioral Analysis (ABA) and other forms of Behavioral Health Treatment (BHT) for autism and pervasive developmental disorders
  2. Electroconvulsive Therapy (ECT)
  3. Half-day partial hospitalization
  4. Intensive Outpatient Program (IOP)

5. Neuropsychological testing
6. Partial Hospital Program or Day Hospital (PHP)
7. Psychological testing
8. Transcranial Magnetic Stimulation (TMS)

- Musculoskeletal procedures
  - Joint surgery
  - Spine surgery
- Neuro stimulator
- Neuropsychological testing
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made)
- Outpatient pharmaceuticals
  1. Self-injectables
  2. All hemophilia factors through the outpatient Prescription Drug benefit require Prior Authorization and must be obtained through the specialty pharmacy vendor.
  3. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, freestanding infusion center, home infusion, Outpatient Surgical Center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net website, www.healthnet.com, for a list of Physician-administered drugs that require Prior Authorization.
  4. Most Specialty Drugs must have Prior Authorization through the outpatient Prescription Drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Essential Drug List to identify which drugs require Prior Authorization. Urgent or emergent drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy. Biosimilars are required in lieu of branded drugs, unless Medically Necessary.
  5. Other Prescription Drugs, as indicated in the Essential Drug List, may require Prior Authorization. Refer to the Essential Drug List to identify which drugs require Prior Authorization.
- Proprietary laboratory analysis
- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  1. Bone alteration or reshaping such as osteoplasty

2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
3. 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.
4. Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection or implants
5. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
8. Hair electrolysis, transplantation or laser removal
9. Lift such as arm, body, face, neck, thigh
10. Liposuction
11. Nasal surgery such as rhinoplasty or septoplasty
12. Otoplasty
13. Penile implant
14. Treatment of varicose veins
15. Vermilionectomy with mucosal advancement

- Testosterone therapy
- Therapy (includes home setting)
  - Occupational therapy
  - Physical therapy
  - Speech therapy
- Transplant and related services; transplants must be performed through Health Net's designated transplantation specialty network.
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vestibuloplasty
- Wound care

Health Net will consider the Medical Necessity of your proposed treatment, your proposed level of care (inpatient or outpatient) and the duration of your proposed treatment.

In the event of an admission, a concurrent review will be performed. Confinement in excess of the number of days initially approved must be authorized by Health Net.

Additional services not indicated in the above list may require Prior Authorization. Please consult the "Schedule of Benefits" section to see additional services that may require Prior Authorization.

Exceptions

Health Net does not require Prior Authorization for maternity care. However, please notify Health Net at the time of the first prenatal visit.

Prior Authorization is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, please notify Health Net within 24 hours following birth or as soon as reasonably possible. Prior Authorization must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

Prior Authorization is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy).

Other than Prescription Drugs, services provided pursuant to a CARE agreement or CARE plan approved by a court do not require Prior Authorization. See "Treatment Related to Judicial or Administrative Proceedings" in the "Exclusions and Limitations" section for more information.

Prior Authorization by Health Net may be required for certain drugs. Please refer to "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" section. You may refer to our website www.healthnet.com to review the drugs that require a Prior Authorization as noted in the Essential Drug List.

Prior Authorization Procedure

Prior Authorization must be requested by you within the following periods:

- Five or more business days before the proposed elective admission date or the commencement of treatment, except when due to a medical emergency.
- 72 hours or sooner, taking into account the medical exigencies, for proposed elective services needed urgently.
- In the event of being admitted into a Hospital following outpatient emergency room or urgent care center services for Emergency Care; please notify the Plan of the inpatient admission within 24 hours or as soon as reasonably possible.
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Services are scheduled to begin.

In order to obtain Prior Authorization, you or your Physician is responsible for contacting Health Net as shown on your Health Net ID card before receiving any service requiring Prior Authorization. If you receive any such service and do not follow the procedures set forth in this "Prior Authorization" section, your benefits are subject to the "Nonauthorization Penalties" as shown in the "Schedule of Benefits" section. However, for services that require notification only, the nonauthorization penalty will not apply.

Health Net will make its decision to approve, modify, or deny Prior Authorization within five (5) business days of receiving your or your Physician's request and within 72 hours of receiving the request if you face an imminent and serious threat to your health.

Verbal Prior Authorization may be given for the service. Written Prior Authorization for inpatient services will be sent to the patient and the provider of service.

If Prior Authorization is denied for a covered service, Health Net will send a written notice to the patient and to the provider of the service.

Effect on Benefits

If Prior Authorization is obtained and services are rendered within the scope of the Prior Authorization, benefits for Covered Expenses will be provided in accordance with the "Covered Services and Supplies" section of this *EOC*.

If Prior Authorization is not obtained, or services, supplies or expenses are received or incurred beyond the scope of Prior Authorization given, the payable percentage will be the reduced percentage as shown in the "Schedule of Benefits" section of this *Evidence of Coverage*. Also, an additional Deductible may be applied to Covered Expenses as shown in the "Schedule of Benefits" section.

Resolution of Disputes

In the event that you or your Physician should disagree with any Prior Authorization decision made, the following dispute resolution procedure must be followed:

- Either you or your Physician may contact Health Net to request an appeal of our decision. Refer to the "Grievance and Appeals Process" provision in the "General Provisions" section for more details. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If you still remain dissatisfied with the reconsideration decision following review by Health Net, you may request an independent review or go through the binding arbitration remedy set forth in the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Binding Arbitration" provisions of the "General Provisions" section of this *EOC*.

MAXIMUM ALLOWABLE AMOUNT (MAA) FOR OUT-OF-NETWORK PROVIDERS

When you receive care from an Out-of-Network Provider, your share of cost is based on the Maximum Allowable Amount. You are responsible for any applicable Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of MAA. You are completely financially responsible for care that this Plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Health Net calculates MAA as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth below. MAA is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Evidence of Coverage*.

- ***Maximum Allowable Amount for covered services and supplies, excluding Emergency Care, pediatric Dental Services and outpatient pharmaceuticals***, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this *Evidence of Coverage*.

For illustration purposes only, Out-of-Network Provider: 70% Health Net Payment, 30% Member Coinsurance:

Out-of-Network Provider's billed charge for extended office visit.....$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount).....$102.40
Your Coinsurance is 30% of MAA: 30% x $102.40 (assumes Deductible has already been satisfied).....$30.72
You also are responsible for the difference between the billed charge ($128.00) and the MAA amount ($102.40).....$25.60
Total amount of $128.00 charge that is your responsibility.....**$56.32**

The Maximum Allowable Amount for facility services, including, but not limited to, Hospital, Skilled Nursing Facility, and outpatient surgery, is determined by applying 150% of the Medicare Allowable Amount.

Maximum Allowable Amount for Physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare Allowable Amount.

In the event there is no Medicare Allowable Amount for a billed service or supply code:

a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same covered services or supplies provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of the Medicare Allowable Amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for covered services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same covered services or supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for covered services.

- ***Maximum Allowable Amount for out-of-network Emergency Care*** will be the greatest of: (1) the median of the amounts negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method Health Net generally uses to determine payments for Out-of-Network providers, excluding any in-network Deductible, Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- ***Maximum Allowable Amount for nonemergent services at an in-network health facility***, at which, or as a result of which, you receive nonemergent covered services by an Out-of-Network Provider, the nonemergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including, but not limited to, injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.
- ***Maximum Allowable Amount for pediatric Dental Services*** is calculated by Health Net based on available data resources of competitive fees in that geographic area and must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services for each covered Dental Service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. Health Net reimburses non-network Dental Providers at 55% of FAIR Health rates. You must pay the amount by which the non-network provider's billed charge exceeds the Eligible Dental Expense.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See the "Schedule of Benefits," "Covered Services and Supplies" and "Exclusions and Limitations" sections for specific benefit limitations, maximums, Prior Authorization requirements and payment policies that limit the amount Health Net pays for certain covered services. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("third-party networks"). In the event Health Net contracts with a third-party network that has a contract with the Out-of-Network Provider, Health Net may, at its option, use the rate agreed to by the third-party network as the Maximum Allowable Amount. Alternatively, we

may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, you will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the out-of-network benefit level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, Health Net will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if you wish to confirm the Covered Expenses for any treatment or procedure you are considering.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for out-of-network services and supplies, please log on to www.healthnet.com or contact Health Net Customer Service at the number on your Member identification card.

COVERED SERVICES AND SUPPLIES

In order for a service or supply to be covered, it must be Medically Necessary. Any covered service may require a Deductible, Copayment, Coinsurance payment or have a benefit limit. Refer to the "Schedule of Benefits" section for details.

In addition, certain covered services and supplies listed herein are subject to Prior Authorization, in many instances, prior to the expenses being incurred. If Prior Authorization is not obtained, the available benefits will be subject to the nonauthorization penalty shown in the "Schedule of Benefits" section. Please refer to the "Prior Authorization Requirement" section for further details.

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.

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

Medical Services and Supplies

Please refer to the "Schedule of Benefits" section of this *Evidence of Coverage* to determine the benefits and cost sharing that apply under each benefit level.

Office Visits

Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals.

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 (http://www.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 (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 screening
- 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), 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, 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, or 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 through Preferred Providers 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" 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 through a Preferred Provider; or
- Covered at the applicable Member cost share when provided by a Nonparticipating Pharmacy or Out-of-Network Provider.

Preventive Care Services received through a Participating Pharmacy or Preferred Provider are covered in full and the Calendar Year Deductible does not apply. Preventive Care Services received through a Nonparticipating Pharmacy or Out-of-Network Provider are covered at the applicable Member cost share after the Calendar Year Deductible has been met.

The Member cost shares above apply to these listed services only.

Surgical Services

Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement. Health Net uses Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with Health Net's normal claims filing requirements.

When adjudicating claims for covered services for the postoperative global period for surgical procedures, Health Net applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable Amount for each additional procedure. Health Net uses Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with Health Net's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

Health Net uses available Medicare guidelines to determine which services and procedures are eligible for payment separately or as part of a bundled package, including, but not limited to, which items are separate professional or technical components of services and procedures. Health Net also uses proprietary guidelines to identify potential billing errors.

Prior Authorization may be required for surgical services. Please refer to the "Prior Authorization Requirement" section for details.

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, 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.

Certain services require Prior Authorization. Please refer to the "Prior Authorization Requirement" section for details.

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services. Please refer to the "Prior Authorization Requirement" section of this *EOC* for details.

Home Visit

Visits by a 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.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained. Please refer to the "Prior Authorization Requirement" section of this *EOC* for details.

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 and Mental Health conditions, subject to any required Prior Authorization from Health Net. The services must be based on a treatment plan authorized, as required by Health Net 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 non-Participating 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" section, under the headings "Care for Conditions of Pregnancy" and "Inpatient Hospital Services" for Copayment and Coinsurance 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.

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 alternate to a Hospital setting, birthing center services are covered when authorized by Health Net and provided by a Preferred Provider. 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.

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 non-medical 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.

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 Prior 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 and scheduled or elective cesarean sections will require Prior Authorization. Please notify Health Net upon confirmation of pregnancy.

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 Prior 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” section for Copayment or Coinsurance requirements.

Medical Social Services

Hospital discharge planning and social service counseling are covered. In some instances, a medical social service worker may refer you to providers or agencies for additional services. These services are covered only if not otherwise excluded under this Plan.

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 Health Net 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.

Payment of benefits will be subject to the nonauthorization penalty shown in the "Schedule of Benefits" section if Prior Authorization is not obtained for home-based physical, speech or occupational therapy.

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. Up to 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.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

Certain drugs that are administered as part of outpatient infusion therapy require Prior Authorization. Refer to the Health Net website, www.healthnet.com, for a list of services and infused drugs that require Prior Authorization.

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.

Covered services provided by an out-of-network ground or air ambulance provider will be payable at the Preferred Provider level of cost sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

Ambulance services that do not meet the criteria for Emergency Care may require Prior Authorization. Please refer to the "Prior Authorization Requirement" section for more information.

Nonemergency ambulance services are covered when Medically Necessary and when your conditions require the use of services that only a licensed ambulance can provide when 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 "Exclusions and Limitations" for additional information.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

Hospice Care

Hospice Care is available for Members diagnosed as terminally ill by a Physician. 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 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.

Payment of benefits will be subject to the nonauthorization penalty shown in the "Schedule of Benefits" section if Prior Authorization is not obtained for the care.

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 condition 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 the InterQual (McKesson) and 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 the "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.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details.

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 needles and 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 "Immunization and Injections" portion of this section).

- Self-management training, education, and medical nutrition therapy will be covered under the in-network tier 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.

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.

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 will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, Health Net 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" section.

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section of this *EOC* for details. Payment of benefits for Prosthetics and Corrective Appliances will be reduced as set forth herein if Prior Authorization is required but not obtained.

Ostomy and Urological Supplies

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

- Ostomy 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.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

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 or Coinsurance which is required when these services are performed by your Participating Provider.

If your Participating Provider refers you to a Physician who is located in the outpatient department of a Hospital, any Copayment or Coinsurance that ordinarily applies to office visits will apply to these services.

Copayments or Coinsurances for the other services will be the same as if they had been performed by your Participating Provider.

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

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

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 the "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 determines 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.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

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.*

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 healthcare 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.

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 Services are not covered if provided by an Out-of-Network Provider.

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 Participating Provider prior to using telehealth consultation services through the Select Telehealth Services Provider.

Prescription Drug Orders received from the Select Telehealth Services Provider or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the "Prescription Drugs" portion of the "Schedule of Benefits" 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.

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 accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable Medical Equipment in accord 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
- 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" section.

Payment of benefits will be reduced as set forth in this *EOC* if Prior Authorization is not obtained for certain services.

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.

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. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your Physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time Prior 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, recreation and any other expenses not specifically listed are specifically excluded.

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

Bariatric surgery is not covered if provided by an Out-of-Network Provider.

Vision and Hearing Examinations

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

Renal Dialysis

Renal dialysis treatment is covered when Medically Necessary. Please notify Health Net upon initiation of renal dialysis treatment.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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.

Coinsurance or Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits" section. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits" 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 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to the *Health Net PPO Provider Directory,* visit our website at www.healthnet.com or contact the Customer Contact Center at the phone number on your Health Net ID card.

Reproductive and Sexual Health Care Services

You may obtain reproductive and sexual health care Physician services without a referral. 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.

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

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 also 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" section.

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

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.

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." 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.

Fertility Preservation

This Plan 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" section as would be required for covered services to treat any illness or condition 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. Health Net will pay for a diabetes instruction program supervised by a Physician. A diabetes instruction program is a program designed to teach you (the diabetic) and your covered Dependent about the disease process, the daily management of diabetic therapy and medical nutrition therapy.

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered if the transplant is Prior Authorized by Health Net. Please refer to the "Prior Authorization Requirement" section for information on how to obtain Prior Authorization.

Health Net has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your 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 or Prior Authorization is obtained. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

If you are outside of California the supplemental network has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Physician can provide you with information about the supplemental network's Transplant Performance Centers. You will be directed to a designated supplemental network Transplant Performance Center at the time Prior Authorization is obtained. Preferred Providers that are not designated as part of the supplemental network's Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services. See the "Out-of-State Providers" provision in the "Miscellaneous Provisions" section for additional information.

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

Organ, tissue and stem cell transplants are not covered if provided by an Out-of-Network Provider.

Acupuncture Services

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

Some of the covered Acupuncture Services are subject to a requirement of Prior Authorization by ASH Plans in order for full benefits to be available to you. Please refer to the "Prior Authorization Requirement" section in *Evidence of Coverage* for additional information.

In-Network Benefits

You may receive covered Acupuncture Services from any Contracted Acupuncturist from the *ASH Plans Contracted Acupuncturist Directory.* 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.

Out-of-Network Benefits

You may obtain covered Acupuncture Services from a non-Contracted Acupuncturist who is available and accessible to you. However, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage* for more details on how we determine MAA.

Covered Acupuncture Services

All covered Acupuncture Services require Prior Authorization by ASH Plans except:

- A new patient examination by an Acupuncturist and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Acupuncture Services, to the extent consistent with professionally recognized standards of practice; and

Office Visits

- A new patient exam or an established patient exam is performed by an 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 an 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.

Mental Health and Substance Use Disorder Benefits

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 and Substance Use Disorder service or supply to be covered, it must be Medically Necessary and authorized, if required, by Health Net. Payment of benefits will be reduced as set forth herein if Prior Authorization is required but not obtained. Please refer to the "Prior Authorization Requirement" section for details.

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

- Outpatient procedures that are not part of an office visit (for example: psychological testing and neuropsychological, outpatient Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)), partial hospitalization, day treatment and half-day partial hospitalization;
- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing and intensive outpatient services; and
- Behavioral health treatment for Pervasive Developmental Disorder or Autism (see below under "Outpatient Services").

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.

How to Obtain Care – In Network

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 nearby Participating Mental Health Professional, 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 will evaluate you, develop a treatment plan for you, and submit that treatment plan to Health Net for review. Upon review and Prior Authorization (if Prior 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 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 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 "Introduction to Health Net" 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.

How to Obtain Care – Out-of-Network

You may also receive care from any licensed Out-of-Network Provider who is not affiliated with Health Net. In this case, however, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Simply schedule an appointment with the provider you desire, and the services will be reimbursed to you based on the Maximum Allowable Amount and your benefits once you submit the claims to Health Net.

Prior Authorization is required for certain services as explained above. Preadmission Prior Authorization and continued stay Prior Authorization is required for both Substance Use Disorder rehabilitation and nonemergency detoxification services. All admissions for rehabilitation are elective and must be authorized as Medically Necessary prior to admission. Inpatient detoxification services are covered only when authorized or as Emergency Care. The Prior Authorization criteria shall not be considered satisfied unless the patient has been personally evaluated by a Physician or other licensed health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

Payment of benefits for Mental Health and Substance Use Disorder services will be subject to the nonauthorization penalty shown in the “Schedule of Benefits” section if Prior Authorization is required but not obtained before you obtain the services.

Emergency care services, regardless of whether the Member is admitted, do not require Prior Authorization.

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic Mental Health 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 at the in-network benefit level, 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 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 of our continuity of care policy, please call the Customer Contact Center at the telephone number on your Health Net ID card.

Covered Services and Supplies

Outpatient Services

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

Covered services include:

- Outpatient office visits/professional consultation including Substance Use Disorders: Includes outpatient crisis intervention, assessment and treatment services, medication management (including detoxification), drug therapy monitoring, and specialized therapy including individual and group Mental Health evaluation and treatment.
- Outpatient services other than an office visits/professional consultation including Substance Use Disorders: Including psychological and neuropsychological testing when necessary to evaluate a Mental Health and 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 freestanding 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, are covered as shown in "Schedule of Benefits" under "Mental Health and Substance Use Disorder."

- The treatment must be prescribed by a licensed Physician or 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 continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Inpatient Services

Inpatient treatment is covered as shown in the "Schedule of Benefits" 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 services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations" section.

Prior Authorization is required for Hospital stay, including the facility and some services received while admitted to the Hospital. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits for Hospital facility stay will be reduced as set forth herein if Prior Authorization is not obtained.

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Mental Health and Substance Use Disorders are covered.

Other Mental Health and Substance Use Disorders

Other Mental Health and Substance Use Disorders are covered as shown in the "Schedule of Benefits" section under "Mental Health and Substance Use Disorders." See also "Mental Health and Substance Use Disorders" in the "Definitions" section.

Transitional Residential Recovery Services

Transitional residential recovery services for Substance Use Disorder in a licensed recovery home when approved by Health Net are covered.

Prescription Drugs

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

You must satisfy the Prescription Drug Deductible shown in the "Schedule of Benefits" section before benefits for Prescription Drugs become payable by Health Net. However, the Prescription Drug Deductible does not apply to diabetic supplies and equipment dispensed through a Participating Pharmacy.

Covered Drugs and Supplies

Medically Necessary Prescription Drugs that are prescribed by a Physician who is either a Preferred Provider or Out-of-Network Provider are covered. Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "Exclusion and Limitations" section to find out if a particular condition is not covered.

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.

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 Member Physician or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net 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, Brand Name Drugs with generic equivalents (when Medically Necessary), 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 Member to have special training or clinical monitoring for self-administration, or drugs that cost the health plan 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.

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 Participating Provider 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 or Coinsurance requirements described in the "Prescription Drugs" portion of the "Schedule of Benefits" 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 (including those designed to assist the visually impaired) and test 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 the "Medical Services and Supplies" portion of this section under "Diabetic Equipment" for additional information. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at 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. Coverage for compounded drugs must be obtained from a Participating Pharmacy, and is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Prescription Drugs" portion of this "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 Health Net's 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.

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 through a Participating Pharmacy. 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 only 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, except for over-the-counter contraceptives, which are covered under this Plan 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 in 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 the Essential Drug 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 Prior Authorization is required. 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 Essential Drug List and it will be mailed to you. The current Essential Drug 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 Essential Drug List is created and maintained by the Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the Essential Drug 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 Essential Drug List. The Essential Drug List is updated as new information and medications are approved by the FDA.

Who Is on the Pharmacy and Therapeutic 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 PPO 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 Process and Step Therapy Exception 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.

Prior Authorization and Step Therapy Exception Process

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" 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 or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard units. 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 refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

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 Deductible, Copayment or Coinsurance shown in the "Schedule of Benefits" section.

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 Deductible, Copayment or Coinsurance.

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.

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 reimbursement.

Health Net will reimburse you for the cost of the Prescription Drug, less any applicable Deductible, Copayment or Coinsurance shown in the "Schedule of Benefits" section.

If you present a prescription order for a Brand Name Drug, the pharmacist will offer a Generic Drug equivalent if commercially available. In cases of Emergency 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 or Urgently Needed Care.

Note: The "Prescription Drug" portion of the "Exclusions and Limitations" section 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 a mail order program selected by Health Net. 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, when appropriate.
- The appropriate Copayment.

You may obtain a Prescription Mail Order Form and further information by contacting the Health Net 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. After you satisfy the Prescription Drug Calendar Year Deductible, the required Copayment or Coinsurance 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 the 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: 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.

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.

Participating Vision Providers

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 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" 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" 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" 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" 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" section. See the "Pediatric Vision Services" portion of the "Schedule of Benefits" 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" 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 Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

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.

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

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.

How to Obtain Care

In-Network Benefits

In-network benefits apply when you choose to obtain covered Dental Services from a Participating Dentist. You generally are required to pay less than you would pay for services from a nonparticipating Dentist. Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge. In no event, will you be required to pay a Participating Dentist an amount for a covered Dental Service in excess of the contracted fee.

A Participating Dentist cannot charge you or us for any service or supply that is not Medically Necessary. If you agree to receive a service or supply that is not Medically Necessary, the Participating Dentist may charge you. However, these charges will not be considered covered Dental Services and benefits will not be payable.

In order for covered Dental Services to be paid as in-network benefits, you must obtain all covered Dental Services directly from a Participating Dentist.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Participating Dentist.

We will make available to you a *Directory of Network Dental Providers*. You can also call Customer Service to determine which providers participate in the network. The telephone number for Customer Service is on your ID card.

Out-of-Network Benefits

Out-of-Network benefits apply when you decide to obtain covered Dental Services from nonparticipating Dentist. You generally are required to pay the difference between Health Net's Maximum Allowable Amount and the dentist's total billed charges. Out-of-network benefits are determined based on the "Maximum Allowable Amount" for pediatric Dental Services as calculated by Health Net, based on available data resources of competitive fees in that geographic area and must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services for each covered Dental Service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. Health Net reimburses nonparticipating Dentist at 55% of FAIR Health rates. The actual charge made by a nonparticipating Dentist for a covered Dental Service may exceed the Maximum Allowable Amount. As a result, you may be required to pay a nonparticipating Dentist an amount for a covered Dental Service in excess of the Maximum Allowable Amount. In addition, when you obtain covered Dental Services from nonparticipating Dentist, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Facilities

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

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 dentist may need additional time to meet your special request.

Making an Appointment

Once your coverage begins, you may contact a dentist of your choice to schedule an appointment. When scheduling an appointment, please identify yourself as a Member. Your 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 *Evidence of Coverage* with you on your appointment. Remember, only pediatric Dental Services listed as covered benefits in this *Evidence of Coverage* are covered.

Orthodontic Benefits

This dental Plan covers orthodontic benefits as described herein. Extractions and initial diagnostic x-rays are not included in these fees.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the *Evidence of Coverage*.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Covered Dental Services

Benefits are provided for the Dental Services stated in this subsection when such services are:

- Medically Necessary;
- Provided by or under the direction of a Dental Provider; and
- Not excluded as described under "Pediatric Dental Services" in the "Exclusions and Limitations" section of this *Evidence of Coverage*.

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.

The fact that a dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is a covered dental Service under this *Evidence of Coverage*.

If you have purchased a supplemental pediatric dental benefit plan, pediatric dental benefits covered under this Plan will be paid first, with the supplemental pediatric dental benefit plan covering 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.

Pediatric Dental Essential Health Benefits:

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
	Diagnostic
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient
D0160	Detailed and extensive oral evaluation - problem focused, by report
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
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal evaluation - new or established patient
D0210	X-rays intraoral - comprehensive series (including bitewings) limited to once per provider every 24 months
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
D0230	X-rays intraoral - periapical each additional film limited to a maximum of 20 periapical in a 12-month period
D0240	X-rays intraoral - occlusal film limited to 2 in a 6-month period
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector - first film
D0251	Extraoral posterior dental radiographic image
D0270	X-rays bitewing - single film limited to once per date of service

Code	Service
D0272	X-rays bitewings - two films limited to once every 6 months
D0273	X-rays bitewings - three films
D0274	X-rays bitewings - four films - limited to once every 6 months
D0277	Vertical bitewings - 7 to 8 films
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service
D0322	Tomographic survey limited to twice in a 12-month period
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)
D0340	2D cephalometric radiographic image limited to twice in a 12-month period per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service
D0396	3D printing of a 3D dental surface scan
D0460	Pulp vitality tests
D0470	Diagnostic casts may be provided only if one of the above conditions is present
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk
D0602	Caries risk assessment and documentation, with a finding of moderate risk
D0603	Caries risk assessment and documentation, with a finding of high risk
D0701	Panoramic radiographic image – image capture only
D0702	2-D cephalometric radiographic image – image capture only
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only
D0706	Intraoral – occlusal radiographic image – image capture only
D0707	Intraoral – periapical radiographic image – image capture only
D0708	Intraoral – bitewing radiographic image – image capture only
D0709	Intraoral – complete series of radiographic images – image capture only
D0801	3D intraoral surface scan – direct

Code	Service
D0802	3D dental surface scan – indirect
D0803	3D facial surface scan – direct
D0804	3D facial surface scan - indirect
D0999	Office visit fee - per visit (unspecified diagnostic procedure, by report)
	Preventive
D1110	Prophylaxis - adult limited to once in a 12-month period
D1120	Prophylaxis - child limited to once in a 6-month period
D1206	Topical fluoride varnish limited to once in a 6-month period
D1208	Topical application of fluoride excluding varnish limited to once in a 6-month period
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330	Oral hygiene instructions
D1351	Sealant - per tooth limited to first, second and third permanent molars that occupy the second molar position
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
D1353	Sealant repair - per tooth
D1354	Interim caries arresting medicament application - per tooth
D1355	Caries preventive medicament application – per tooth
D1510	Space maintainer - fixed - unilateral limited to once per quadrant
D1516	Space maintainer - fixed – bilateral, maxillary
D1517	Space maintainer - fixed – bilateral, mandibular
D1520	Space maintainer - removable - unilateral limited to once per quadrant
D1526	Space maintainer - removable – bilateral, maxillary
D1527	Space maintainer - removable – bilateral, mandibular
D1551	Re-cement or re-bond bilateral space maintainer – maxillary
D1552	Re-cement or re-bond bilateral space maintainer – mandibular
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant

Code	Service
D1556	Removal of fixed unilateral space maintainer - per quadrant
D1557	Removal of fixed bilateral space maintainer - maxillary
D1558	Removal of fixed bilateral space maintainer - mandibular
D1575	Distal shoe space maintainer - fixed - unilateral - per quadrant
	Restorative
D2140	Amalgam - one surface, primary limited to once in a 12-month period
D2140	Amalgam - one surface, permanent limited to once in a 36-month period
D2150	Amalgam - two surfaces, primary limited to once in a 12-month period
D2150	Amalgam - two surfaces, permanent limited to once in a 36-month period
D2160	Amalgam - three surfaces, primary limited to once in a 12-month period
D2160	Amalgam - three surfaces, permanent limited to once in a 36-month period
D2161	Amalgam - four or more surfaces, primary limited to once in a 12-month period
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36-month period
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12-month period
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36-month period
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12-month period
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36 month period
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12-month period
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36-month period
D2335	Resin-based composite - four or more surfaces (anterior) primary limited to once in a 12-month period
D2335	Resin-based composite - four or more surfaces (anterior) permanent limited to once in a 36-month period
D2390	Resin-based composite crown, anterior, primary limited to once in a 12-month period

Code	Service
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36-month period
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12-month period
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36-month period
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12-month period
D2392	Resin-based composite - two surfaces, posterior; permanent limited to once in a 36-month period
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12-month period
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36-month period
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12-month period
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36-month period
D2710	Crown - resin-based composite (indirect) limited to once in a 5-year period
D2712	Crown - ¾ resin-based composite (indirect) limited to once in a 5-year period
D2721	Crown - resin with predominantly base metal limited to once in a 5-year period
D2740	Crown - porcelain/ceramic limited to once in a 5-year period
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5-year period
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5-year period
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5-year period
D2791	Crown - full cast predominantly base metal limited to once in a 5-year period
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core
D2920	Recement or re-bond crown
D2921	Reattachment of tooth fragment, incisal edge or cusp
D2928	Prefabricated porcelain/ceramic crown – permanent tooth

Code	Service
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12-month period
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12-month period
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36-month period
D2932	Prefabricated resin crown, primary limited to once in a 12-month period
D2932	Prefabricated resin crown, permanent limited to once in a 36-month period
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12-month period
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36-month period
D2940	Placement of interim direct restoration limited to once per tooth in a 12-month period
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed
D2955	Post removal
D2957	Each additional prefabricated post - same tooth
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework
D2976	Band stabilization – per tooth
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.
D2989	Excavation of a tooth resulting in the determination of nonrestorability
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure, by report

Code	Service
	Endodontics
D3110	Pulp cap - direct (excluding final restoration)
D3120	Pulp cap - indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth
D3221	Pulpal debridement primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment
D3320	Endodontic (root canal) therapy, premolar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment
D3331	Treatment of root canal obstruction; nonsurgical access
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - premolar
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth
D3410	Apicoectomy - anterior
D3421	Apicoectomy - premolar (first root)
D3425	Apicoectomy - molar (first root)
D3426	Apicoectomy (each additional root)
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site

Code	Service
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site
D3430	Retrograde filling - per root
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report
	Periodontics
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months
D4249	Clinical crown lengthening - hard tissue
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
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
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910	Periodontal maintenance limited to once in a calendar quarter

Code	Service
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)
D4999	Unspecified periodontal procedure, by report
	Prosthodontics, removable
D5110	Complete denture - maxillary limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture
D5120	Complete denture - mandibular limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period
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
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
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12-month period
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12-month period
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12-month period

Code	Service
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12-month period
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
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
D5611	Repair resin denture base, mandibular
D5612	Repair resin denture base, maxillary
D5621	Repair cast framework, mandibular
D5622	Repair cast framework, maxillary
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
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
D5650	Add tooth to existing partial denture - per tooth - limited to a maximum of three, per date of service; once per tooth
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
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period

Code	Service
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period
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.
D5862	Precision attachment, by report
D5863	Overdenture - complete maxillary
D5864	Overdenture - partial maxillary
D5865	Overdenture - complete mandibular
D5866	Overdenture - partial mandibular
D5899	Unspecified removable prosthodontic procedure, by report
	Maxillofacial Prosthetics
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive

Code	Service
D5933	Obturator prosthesis, modification limited to twice in a 12-month period
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification limited to twice in a 12-month period
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report
	Implant Services
D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar - implant supported or abutment supported

Code	Service
D6056	Prefabricated abutment - includes modification and placement
D6057	Custom fabricated abutment - includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown (porcelain fused to high noble alloys)
D6067	Implant supported crown (high noble alloys)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD (porcelain fused to high noble alloys)
D6077	Implant supported retainer for metal FPD (high noble alloys)
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
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
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys

Code	Service
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Interim implant crown
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw – per screw
D6090	Repair of implant/abutment supported prosthesis
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6094	Abutment supported crown - titanium and titanium alloys
D6096	Removal of broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6105	Removal of implant body not requiring bone removal or flap elevation
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular

Code	Service
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD - predominantly base alloys
D6122	Implant supported retainer for metal FPD - noble alloys
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement
D6192	Semi-precision attachment – placement
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
D6198	Remove interim implant component
D6199	Unspecified implant procedure, by report
	Fixed Prosthodontics
D6211	Pontic - cast predominantly base metal limited to once in a 5-year period
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5-year period
D6245	Pontic - porcelain/ceramic limited to once in a 5-year period
D6251	Pontic - resin with predominantly base metal limited to once in a 5-year period
D6721	Retainer crown - resin predominantly base metal - denture limited to once in a 5-year period
D6740	Retainer crown - porcelain/ceramic limited to once in a 5-year period
D6751	Retainer crown - porcelain fused to predominantly base metal limited to once in a 5-year period
D6781	Retainer crown - ¾ cast predominantly base metal limited to once in a 5-year period
D6783	Retainer crown - ¾ porcelain/ceramic limited to once in a 5-year period

Code	Service
D6784	Retainer crown - ¾ titanium and titanium alloys
D6791	Retainer crown - full cast predominantly base metal limited to once in a 5-year period
D6930	Recement or re-bond fixed partial denture
D6980	Fixed partial denture repair necessitated by restorative material failure
D6999	Unspecified fixed prosthodontic procedure, by report
	Oral and Maxillofacial Prosthetics
D7111	Extraction, coronal remnants - primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7252	Partial extraction for immediate implant placement
D7259	Nerve dissection
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
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
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth
D7284	Excisional biopsy of minor salivary glands
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment

Code	Service
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment
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.
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) limited to once in a 5-year period per arch
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
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only

Code	Service
D7472	Removal of torus palatinus limited to once in a patient's lifetime
D7473	Removal of torus mandibularis limited to once per quadrant
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant
D7490	Radical resection of maxilla or mandible
D7509	Marsupialization of odontogenic cyst
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service
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
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone limited to once per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction

Code	Service
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Nonarthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - lavage and lysis of adhesions
D7874	Arthroscopy - disc repositioning and stabilization
D7875	Arthroscopy - synovectomy
D7876	Arthroscopy - discectomy
D7877	Arthroscopy - debridement
D7880	Occlusal Orthotic device, by report
D7881	Occlusal Orthotic device adjustment
D7899	Unspecified TMD therapy, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm

Code	Service
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7961	Buccal/labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty limited to once per arch per date of service
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service
D7979	Nonsurgical sialolithotomy
D7980	Surgical sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty

Code	Service
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service
D7999	Unspecified oral surgery procedure, by report
	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.)
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
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

Code	Service
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia
D9222	Deep sedation/general anesthesia - first 15 minutes
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment
D9248	Nonintravenous conscious sedation
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician
D9311	Consultation with a medical health professional
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a benefit
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service
D9612	Therapeutic parenteral drug, two or more administrations, different medications
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only
D9930	Treatment of complications - post surgery, unusual circumstances, by report limited to once per date of service
D9950	Occlusion analysis - mounted case limited to once in a 12-month period
D9951	Occlusal adjustment - limited. Limited to once in a 12-month period per quadrant

Code	Service
D9952	Occlusal adjustment - complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)
D9995	Teledentistry – synchronous; real-time encounter
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management - patients with special health care needs
D9999	Unspecified adjunctive procedure, by report

Dental codes from "Current Dental Terminology© American Dental Association."

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.

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.

Services and Supplies

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 "Covered Services and Supplies."

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 Prior Authorization was obtained, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies;" 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.

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 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.

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.

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.

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 breast.

Health Net determines the feasibility and extent of these services. These services are subject to the Prior Authorization requirements described in the "Prior Authorization Requirement" section of this *Evidence of Coverage*. However, 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.***

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures will be subject to the Prior Authorization requirements described in the "Prior Authorization Requirement" section. However, Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Prior Authorization for determining the length of stay will not be required.

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 "Definitions" sections for services that are provided as part of that care, when authorized by Health Net.

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 the "Pediatric Dental Services" portion of "Covered Services and Supplies":

- 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, (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 the "Covered Services and Supplies" section 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.

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/TMJ disorders are 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.

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.

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 or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.
- Orthodontic appliances to treat dental conditions related to the treatment 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 "Covered Services and Supplies."
- 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.

Excess Charges

Amounts charged by Out-of-Network Providers for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as described in the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*.

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.

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.

Governmental Agencies

Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.

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.

Home Birth

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

Immunizations and Injections

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

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.

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.

Inpatient Diagnostic Tests

Inpatient room and board charges incurred in connection with an admission to a Hospital or other inpatient treatment facility primarily for diagnostic tests which could have been performed safely on an outpatient basis.

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.

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.

Noncovered Treatments

The following types of treatment are only covered when provided in connection with covered treatment for Mental Health and Substance Use Disorders:

- 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, Substance Use Disorder treatment. This provision does not impair coverage for the Medically Necessary treatment of any Mental Health conditions identified as a Mental Health and Substance Use Disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth 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, Fifth Edition, Text Revision*, as amended in the most recently issued edition.

Noneligible Hospital Confinements

Inpatient room and board charges in conjunction with a Hospital, Hospice or Skilled Nursing Facility stay primarily for environmental change, personal convenience or custodial in nature are not covered.

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 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.

Nonlicensed Provider

Treatments or services rendered by health care providers who are required to be, but who are not, licensed by the state where they practice to provide the treatments or services. Treatment or services for which the provider of services is not required to be licensed are also excluded from coverage. This includes treatment or services from a nonlicensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by Health Net. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in this *Evidence of Coverage* or certain Mental Health and Substance Use Disorder therapy and social work providers in training working under a licensed provider.

Nonstandard Therapies

Services that do not meet national standards for professional medical or Mental Health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, 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.

Not Medically Necessary

Services or supplies that are not Medically Necessary, as defined in the "Definitions" section. However, the *Evidence of Coverage* 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).

Personal or Comfort Items

This Plan does not cover personal or comfort items.

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 tests 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.

Private Rooms

Expenses in excess of a Hospital's (or other inpatient facility's) most common semi-private room rate unless Prior Authorized by Health Net.

Psychological Testing

Psychological testing except as conducted by 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 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 Disorder, 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 Prior Authorization from Health Net. The services must be based on a treatment plan as authorized. 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 plan goals. See the “General Provisions” section for the procedure to request 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 Disorder, 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.

Reversal of Surgical Sterilization

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

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 or Coinsurance 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.

Services for Educational or Training Purposes

Except for services related to behavioral health treatment for pervasive development disorder or autism 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).

Sober Living Facilities

Expenses related to a stay at a sober living facility. This exclusion does not apply to licensed Residential Treatment Centers.

Sports Activities

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

State Hospital Treatment

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

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 services 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 (medical) or a Mental Health Professional (Mental Health and 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 the "Covered Services and Supplies" section.

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: 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 may require Prior Authorization.

Vision Therapy, Eyeglasses and Contact Lenses

This Plan does not cover vision therapy, Eyeglasses or contact Lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Prescription Drugs

The exclusions and limitations in all the "Services and Supplies" portions of this section also apply to the coverage of Prescription Drugs.

Note: 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" section and the "Immunizations and Injections" portion of "Covered Services and Supplies" section for more information.

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" portion of the "Prescription Drugs" portion of

"Covered Services and Supplies." 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" provision 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 “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 nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

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 narcotic drugs are not covered through mail order. 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.

Self-Injectable Drugs

Self-injectable drugs obtained through a prescription from a Physician are limited to insulin, and sexual dysfunction drugs and injections listed on the Essential Drug List as Specialty Drugs. 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 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: 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.

Noncontracted 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: 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:

Non-Participating 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 "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" 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" section for additional limitations.

Note: 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 the "Covered Services and Supplies" section for more information.

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 "Exclusions and Limitations" "Dental Services."
- 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 "When Coverage Ends" in the "Eligibility, Enrollment and Termination" section 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.

Prior Deductible Carryover Credit

Prior Deductible carryover credit applies if this Plan is replacing a similar plan that had been issued to the Group. If a Member has satisfied any portion of the Deductible under the prior carrier plan, the credit shall apply to the satisfaction of the Member's initial Calendar Year Deductible under this *Evidence of Coverage*. Proof of Deductible satisfaction under the prior carrier plan will be required upon submission of the initial claim for benefits to be payable under this *Evidence of Coverage*.

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, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center or 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 **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 Health Net 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, 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 with Health Net, 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:

1. 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;
2. 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

3. 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 Health Net's 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 bilateral 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 the total damages are 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
PO 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 the 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.

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 provider's effort 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 in 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, as summarized below, and 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 medical provider 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 medical provider will also be reduced a pro rata 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 medical provider 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

Participating Providers, 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 Participating Provider, 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 Participating Providers, any Physician or Hospital or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of this Plan.

Provider/Patient Relationship

Participating 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 Participating Provider. If this happens, the Participating 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 Deductible, Copayment, or Coinsurance 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.

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.

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a Preferred Provider is terminated, Health Net will make every effort to ensure continuity of care. A Member may request continued care from an Out-of-Network Provider at the in-network benefit level, if at the time of provider contract 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 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.

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 the request is made 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.

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 (COB) 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: 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; or
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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 noncustodial parent.
- The Plan of the spouse of the noncustodial 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 Group Plan to that of a multiple Group 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 the "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.

The "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. 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 Part 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 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 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, Health Net will cover the services 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

In most instances, you will not need to file a claim when you receive covered services and supplies from a Preferred Provider. If you use an Out-of-Network Provider and file a claim, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Deductible, Copayment or Coinsurance, and the amount in excess of the Maximum Allowable Amount. 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 from Preferred Providers. However, if you utilize Out-of-Network Providers, you will need to file a claim and 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 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 claim forms.

If you need to file a claim for services covered under the medical or Mental Health and Substance Use Disorder benefit, 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's 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 Health Net 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 the Customer Contact Center 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.

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.

Payment to Providers or Subscriber

Benefit payment for Covered Expenses will be made directly to:

- Hospitals which have provider service agreements with Health Net to provide services to you (contracting Hospitals);
- Providers of ambulance transportation. However, if the submitted provider's statement or bill indicates the charges have been paid in full, payment will be made to the Subscriber; or
- Other providers of service not mentioned above, Hospital and professional when required by law or at Health Net's election if you agree, in writing.

In situations not described above, payment will be made to the Subscriber.

Payment When Subscriber is Unable to Accept

If a claim is unpaid at the time of the Member's death or if the Member is not legally capable of accepting it, payment will be made to the Member's estate or any relative or person who may legally accept on the Member's behalf.

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.

Physical Examination

Health Net, at its expense, has the right to examine or request an examination of any Member whose injury or sickness is the basis of claim as often as is reasonably required while the claim is pended.

Foreign Travel or Work Assignment

Benefits will be provided for Emergency Care and Urgently Needed Care received in a foreign country. Determination of a Covered Expense will be based on the amount that is no greater than the Maximum Allowable Amount paid in the USA for the same or a comparable service.

Out-of-State Providers

Health Net PPO allows you access to Participating Providers outside of California. If you are outside California, require medical care or treatment, and use a provider from the supplemental network, your services are covered at the in-network benefit level. If your principal residence is outside of California, all in-network services are through the supplemental network.

You will be subject to the same Deductibles, Copayments, Coinsurances, maximums and limitations as you would be if you obtained services from a Preferred Provider in California. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between Health Net and the network. In a small number of states, local statutes may dictate a different basis for calculating your Covered Expenses.

The supplemental network, as shown on your Health Net ID card, consists of providers who participate in a network that agree to provide Health Care Services to Health Net Members.

Interpretation of Evidence of Coverage

The laws of the state of California shall be applied to interpretations of this *Evidence of Coverage*.

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 Participating Provider 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 “Introduction to Health Net.”

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 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; and
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We are also committed to 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.

***This Notice of Privacy Practices also applies to enrollees in any of the following:** 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. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved Rev. 07/30/25.

- 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, 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, health care providers, and health care 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: sex, race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, mental or physical disability, ethnic group identification or medical genetic information.

- ***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: 1-883-887-0151
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
DHCS Privacy Officer
1501 Capitol Avenue, MS 0010
Sacramento, CA 95899

Phone: 1-866-866-0602 or TTY: 711
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:

- on applications or other forms, such as name, address, age, Medical Information and Social Security number;
- your transactions with us, our affiliates or others, such as premium payment and claims history; and
- 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.

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

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.

Average Wholesale Price ("AWP") for any Prescription Drug is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by Health Net.

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. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for 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 still under patent, 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 continuous twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Calendar Year Deductible is the amount of medical and outpatient Prescription Drug Covered Expenses which must be incurred by you or your family each Calendar Year and for which you or your family have payment responsibility before benefits become payable by Health Net.

Coinsurance is the percentage of the Covered Expenses, for which the Member is responsible, as specified in the "Schedule of Benefits" section.

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.

Contracted Rate is the rate that Preferred Providers are allowed to charge you, based on a contract between Health Net and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in the "Schedule of Benefits" 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.

Covered Expenses are expenses incurred by the Member for covered medical services and treatment (including covered services related to Mental Health and Substance Use Disorders) while covered under this Plan. It is not necessarily the amount a Physician or provider bills for a service. The amount of Covered Expenses varies by whether the Member obtains services from a Preferred Provider or an Out-of-Network Provider. Any expense incurred which exceeds the following amounts is not a Covered Expense: (i) for the cost of services or supplies from a Preferred Provider, the Contracted Rate; (ii) for the cost of services or supplies from an Out-of-Network Provider, the Maximum Allowable Amount. For more details about the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*.

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.

Deductible is a set amount you pay 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).

Dental Provider is any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures is dental care or treatment provided by a Dental Provider to a Member while the *Evidence of Coverage* is in effect, provided such care or treatment is a generally accepted form of care or treatment according to prevailing standards of dental practice.

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 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 and/or Coinsurance 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.

Eligible Dental Expenses for covered pediatric Dental Services are determined as stated below:

- For in-network benefits, when covered Dental Services are received from Participating Dentists, Eligible Dental Expenses are our contracted fee(s) for covered Dental Services with that provider.
- For out-of-network benefits, when covered Dental Services are received from nonparticipating Dentists, Eligible Dental Expenses is the Maximum Allowable Amount, as described in the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*.

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.

With regard to Acupuncture Services, "Experimental" services are acupuncture care that is a currently unproven Acupuncture Service and does not meet professionally recognized, valid, evidence-based standards of practice.

Please refer to the "Independent Medical Review of Investigational or Experimental Therapies" provision of the "General Provisions" section as well as the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for additional information.

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) 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 California licensed health care service plan.

Health Net PPO is the Preferred Provider Organization (PPO) plan described in this *Evidence of Coverage*, which allows you to obtain covered services and supplies from either a network of Preferred Providers or Out-of-Network Providers.

Health Net PPO 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 Groups 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.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in your home.

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 Amount is the amount on which Health Net bases its reimbursement for covered services and supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth in the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*. Maximum Allowable Amount is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles, and other applicable amounts set forth in this *Evidence of Coverage*.

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net. To get an estimate of charges for Prescription Drugs that are subject to a Deductible, visit the Health Net website at www.healthnet.com or call Health Net's Customer Contact Center at the number shown on your Health Net ID card.

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: Medically Necessary (or Medical Necessity) 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:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. 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.

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.

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.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Medicare Allowable Amount: Health Net uses available guidelines of Medicare to assist in its determination as to which services and procedures are eligible for reimbursement. Health Net will, to the extent applicable, apply Medicare claim processing rules to claims submitted. Health Net will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the Maximum Allowable Amount, as defined above, if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

The Medicare Allowable Amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

Member is the Subscriber or an enrolled Family Member.

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. 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, Fifth Edition, Text Revision*, as amended in the most recently issued edition.

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.

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-Network Providers are Physicians, Hospitals, laboratories or other providers of health care who are not part of the Health Net Preferred Provider Organization (PPO) Network, or the supplemental network outside of California.

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Coinsurance and Copayment for covered services for which the Member is responsible in a Calendar Year. Deductibles, Copayments and Coinsurance 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. Services provided at a facility under the out-of-network level of benefit must meet these same licensing requirements.

Participating Dentist is a Dental Provider 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 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. Services provided by a Mental Health professional under the out-of-network benefit level must meet these same licensing requirements.

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.

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 Providers (See "Preferred Providers" definition).

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. Care from the following providers is also covered, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this *Evidence of Coverage* and when benefits would be payable if the services were provided by a Physician as defined above:

Dentist (D.D.S.)
Optometrist (O.D.)
Dispensing optician
Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
Psychologist
Acupuncturist (A.C.)
Nurse midwife
Nurse Practitioner
Physician Assistant
Clinical social worker (M.S.W. or L.C.S.W.)
Marriage, family and child counselor (M.F.C.C.)
Physical therapist (P.T. or R.P.T.)
Speech pathologist
Audiologist
Occupational therapist (O.T.R.)
Psychiatric Mental Health nurse
Respiratory care practitioner
Other Mental Health and Substance Use Disorder providers, including, but not limited to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

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.

Plan is the health benefits purchased by the Group and described in the Group Service Agreement and this *Evidence of Coverage*.

Preferred Providers are Physicians, Hospitals, laboratories or other providers of health care who have a written agreement with Health Net to participate in the Health Net Preferred Provider Organization (PPO) and have contracted to provide the Members of Health Net with health care at a contracted rate (the Contracted Rate), except as specified under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center." The Contracted Rate will be the contracted amount that will serve as payment in full for the Member. Preferred Providers are listed in the *Health Net PPO Network Directory.*

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 Allowable Charge is the lesser of pharmacy's cost of the prescription or is the charge that Participating Pharmacies and the mail service program have agreed to charge Members, based on a contract between Health Net and such provider.

Prescription Drug Covered Expenses are the maximum charges Health Net will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order; it is not necessarily the amount the pharmacy will bill. Any expense incurred which exceed the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; and (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

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) directly related to the treatment of an illness or injury and which is issued by a Physician within the scope of their professional license.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in the "Schedule of Benefits" and "Covered Services and Supplies" sections. 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

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 and Step Therapy Exception 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 and 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 and 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;
  - 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; and

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 "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 Physician who delivers specialized services and supplies to the Member.

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.

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 state 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 or the supplemental network (outside of 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 and the supplemental network's Transplant Performance Centers includes any providers in Health Net's or the supplemental network's designated supplemental resource network. Preferred Providers that are not designated as part of Health Net's network or the supplemental network's Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services. See the "Out-of-State Providers" provision in the "Miscellaneous Provisions" section for additional information.

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.

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.

FLY065732EP00 (05/25)

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

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Contact us

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
1-800-522-0088 TTY: 711

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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