Health Net of California, Inc. (Health Net)

Disclosure Form

PPO

Small Group Plans

Refer to the Summary of Benefits and Coverage (SBC) document to determine your share of costs for services and supplies that are covered by this plan.

Healthnet.com

Delivering Choices

When it comes to your health care, it's nice to have options. That's why Health Net of California, Inc. (Health Net) offers a Preferred Provider Organization (PPO) plan (called "Health Net PPO") – a plan that offers you flexibility and choice. This *Disclosure Form* answers basic questions about Health Net PPO.

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

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

If you have further questions, contact us:

By phone at 1-800-522-0088

By mail at:

Health Net of California
P.O. Box 9103
Van Nuys, CA 91409-9103

Online at www.healthnet.com

This *Disclosure Form* (including any applicable *Disclosure Form Rider*) and the *Summary of Benefits and Coverage (SBC)* document provide a summary of your health plan. The plan's *Evidence of Coverage (EOC)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You have the right to view the *EOC* prior to enrollment. To obtain a copy of the *EOC*, contact the Customer Contact Center at 1-800-522-0088. You should also consult the *Group Hospital and Professional Service Agreement* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this *Disclosure Form*, the *SBC* and, once received, the plan's *EOC*, especially those sections that apply to those with special health care needs. This *Disclosure Form* includes a matrix of benefits in the section titled "Benefits Matrix." The *SBC*, which is issued in conjunction with this *Disclosure Form*, describes what your plan covers and what you pay for covered services and supplies.

Table of Contents

How the Plan Works

Please read the following information so you will know from whom health care may be obtained.

CHOICE OF PROVIDERS

When you enroll in the Health Net PPO plan, you choose your own doctors and hospitals for all your health care needs. Health Net PPO offers two different ways to access care:

- **In-network** - You choose a contracted doctor (or hospital) within our PPO network. You can take advantage of significant cost savings when you receive care from a provider who is contracted with Health Net PPO.
- **Out-of-network** - You choose a doctor (or hospital) outside of our PPO network. These providers do not have a contract with Health Net PPO. You will incur higher out-of-pocket costs than when you see a provider within our PPO network.

Except for emergency care, when you choose to see an out-of-network provider, you will pay the cost-sharing for the out-of-network benefit level, which is typically higher than the in-network benefit level. ***Plus****, you are responsible for the difference between the amount the out-of-network provider bills and the maximum allowable amount (MAA). See "Payment of Fees and Charges" later in this Disclosure Form for more details.*

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. Providers who are contracted with Health Net PPO are called "preferred providers" and they are listed on our website at www.healthnet.com. You can also call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the *Health Net PPO Preferred Provider Directory* at no cost.

In some instances, ***prior authorization*** *(also known as preauthorization or treatment review) is required for full benefits to be paid. Refer to the "Prior Authorization Requirements" section of this Disclosure Form to find out which services or supplies require prior authorization.*

SPECIALISTS CARE

If you need specialty care, you are free to see any specialist without a referral. Simply call and schedule an appointment. To lower your share of costs, obtain care at the in-network benefit level by seeing a specialist within our PPO network. Refer to the *Health Net PPO Preferred Provider Directory* to locate specialists within our PPO network.

You also do not need approval from Health Net or from any other person in order to obtain access to obstetrical, gynecological, reproductive or sexual health care from an in-network health care professional who specializes in obstetrics, gynecology or reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining

prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health, refer to your *Health Net PPO Preferred Provider Directory* on the Health Net website at www.healthnet.com. A copy of the *Health Net PPO Preferred Provider Directory* may also be ordered online or by calling Health Net Customer Contact Center at **1-800 522-0088**.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

For more information about how to receive care and Health Net's prior authorization requirements, please refer to the "Behavioral Health Services" and "Prior Authorization Requirements" sections of this *Disclosure Form*.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *Evidence of Coverage* and that you or your family member might need:

- **Family planning**
- **Contraceptive services; including emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **Infertility treatments**
- **Abortion**

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call the Health Net Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.

Benefits Matrix

The matrix below lists examples of services that are provided under this plan. Refer to the *SBC*, which is issued in conjunction with this *Disclosure Form*, for the amount you will pay for covered services and supplies.

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

Principal Benefits	What You Pay
Deductible	The *SBC* shows if your plan has a deductible that has to be met before we begin to pay the benefits.
Lifetime maximums	This plan does not have a lifetime maximum.
Professional services	Refer to the *SBC* under "If you visit a health care provider's office or clinic."
Outpatient services	Refer to the *SBC* under "If you have outpatient surgery."
Hospitalization services	Refer to the *SBC* under "If you have a hospital stay."
Emergency health coverage	Refer to the *SBC* under "If you need immediate medical attention."
Ambulance services	Refer to the *SBC* under "If you need immediate medical attention."
Prescription drug coverage	Refer to the *SBC* under "If you need drugs to treat your illness or condition."
Durable medical equipment	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Mental health services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Substance use disorder services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Home health services	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Other services	Refer to the *SBC* under "If you have a test" and "If you need help recovering or have other special health needs."
Pediatric vision care	Pediatric vision benefits are administered by EyeMed Vision Care, LLC. Refer to the "Pediatric Vision Care Program" section later in this *Disclosure Form* for the benefit information which includes the eyewear schedule.

Pediatric dental services	Pediatric dental benefits are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Refer to the "Pediatric Dental Program" section later in this *Disclosure Form* for the benefit information. See the *EOC* for additional details.

Prior Authorization Requirements

For certain covered services, you must obtain prior authorization before receiving the services or you will be required to pay the nonauthorization penalty as shown in the *SBC* and the *EOC*. Prior authorizations are performed by Health Net or an authorized designee.

We may revise the prior authorization list from time to time. Any such changes including additions and deletions from the list will be communicated to preferred 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 prior authorized, eligibility rules and benefit limitations will still apply. However, Health Net will not rescind or modify prior authorization after a provider renders health care services in good faith and pursuant to the prior authorization, and will pay benefits under the *Evidence of Coverage* for the services prior authorized.

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

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 use disorder 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)
     - Multigated acquisition (MUGA) scan
     - Myocardial perfusion imaging (MPI)
  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, including self-injectable drugs and hemophilia factors, 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 injections 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 (including home settings)
  - 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

Exceptions: *Prior authorization is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy). 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.*

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained;
- 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;

- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental health and substance use disorders, except when such services are medically necessary. **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" in your plan's *SBC* and may require prior authorization;
- Chiropractic services, unless shown as covered on your plan's *SBC*;
- Corrective footwear is limited to medically necessary footwear that is custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan, or is a podiatric device to prevent or treat diabetes-related complications. Other corrective footwear is not covered unless specifically described in your plan's *EOC*;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services for members age 19 and over. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use except certain disposable ostomy or urological supplies;
- Experimental or investigational procedures, except as set out under the "Clinical Trials" and "If You Have a Disagreement with Our Plan" sections of this *Disclosure Form*;
- Fertility preservation coverage 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; or gestational carriers (surrogates);
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. However, prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer;
- Hearing aids;
- Immunizations and injections for foreign travel/occupational purposes;
- Infertility services and supplies, unless shown as covered on your plan's *SBC*;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental health or substance use disorder;

- Noneligible institutions. This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the plan's *EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescription drugs (except as noted under "Prescription Drug Program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless medically necessary;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *EOC*;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity. Certain services may be covered as preventive care services as described in the plan's *EOC*.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The *EOC*, which you will receive if you enroll in this plan, will contain the full list.

Benefits and Coverage

MEDICALLY NECESSARY CARE

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

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances for urgently needed care, you may seek care by going to your physician (medical) or participating mental health professional (mental health and substance use disorders) or urgent care center. For an emergency, go to the nearest emergency facility or call **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including mental health and substance use disorders) that requires an emergency response. All air and ground ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including mental health and substance use disorders). You can also call 988, the national suicide and mental health crisis hotline system.

Emergency care is covered at the in-network benefit level and does not require prior authorization. All follow-up care (including mental health and substance use disorders) after the urgency has passed and your condition is stable will be covered at whichever benefit level (in-network or out-of-network) it qualifies for, subject to any applicable prior authorization requirements, and your plan's exclusions and limitations.

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. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) A transfer poses a threat to the health and safety of the member or unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of 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.

All air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including mental health and substance use disorders).

***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: (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.*

***Emergency psychiatric medical condition** means a mental health or substance use disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (1) an immediate danger to themself or to others, or (2) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health or substance use disorder.*

***Urgently needed care** includes an 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.*

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the federal Newborns' and Mothers' Health Protection Act of 1996 and Women's Health and Cancer Rights Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum hospital length of stay following delivery. Specifically, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

TIMELY ACCESS TO CARE TO 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. Providers within the Health Net PPO network agree to provide timely access to care.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the plan's *EOC* or contact the Health Net Customer Contact Center at the phone number on the back cover.

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

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. For further information, please refer to the plan's *EOC*.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered for 31 days (including the date of birth). To continue coverage, the child must be enrolled through your employer before the 60th day of the child's life. If the child is not enrolled within 60 days (including the date of birth):

- Coverage will end after 31 days (including the date of birth); and
- You will have to pay for all medical care provided after 31 days (including the date of birth).

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from a Medi-Cal plan.

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.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, we may cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

CONFIDENTIALITY AND RELEASE OF MEMBER INFORMATION

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

PRIVACY PRACTICES

Once you become a Health Net member, Health Net uses and discloses a member’s protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual’s rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for nonroutine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member’s protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health

information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in the plan's *EOC* or at www.healthnet.com under "Privacy Practices" or you may call the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

* *Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

Utilization Management

Utilization management is an important component of health care management. Through the processes of prior authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net's high quality medical management standards.

PRIOR AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where prior authorization was required but not obtained.

CARE OR CASE MANAGEMENT

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

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Customer Contact Center at the phone number on the back cover.

Payment of Fees and Charges

PREPAYMENT FEES

Your employer will pay Health Net your monthly subscription charges for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

COVERED EXPENSES

Covered expenses are expenses incurred by you for covered services and supplies while enrolled under this plan. You are responsible for payment of your share of the cost of services (i.e., deductibles, copayments or coinsurance). Your share of cost is based on covered expenses.

A covered expense is not necessarily the amount a doctor or provider bills for a service. The amount of covered expenses varies by whether you obtain services from a preferred provider or an out-of-network provider. For a preferred provider, a covered expense is the contracted rate. For an out-of-network provider, a covered expense is the maximum allowable amount. See "Maximum Allowable Amount (MAA) for Out-of-Network Providers" later in this section for more information.

OTHER CHARGES

The *SBC* explains your coverage and payment for services. Please take a moment to look it over.

With Health Net PPO, you are responsible for paying a portion of the costs for your care. Amounts paid by you are called **deductible**, **copayment** and **coinsurance**, which are described in the *SBC*. The amount you pay can vary from a flat amount to a significant percentage of the costs. It all depends on the doctor (and hospital) you choose. In general:

- If your benefits are subject to a deductible, you must pay the deductible before we begin to pay for those benefits.
- You pay less when you receive care from doctors or hospitals that are contracted with our PPO, since they have agreed in advance to provide services for a specific fee (a contracted rate). You will only pay the applicable in-network deductible, copayment or coinsurance. Preferred providers have agreed to accept the contracted rate as payment in full and may not bill you for charges in excess of the contracted rate.

- If you receive care from out-of-network doctors or hospitals, you will be responsible for the applicable out-of-network deductible, copayment or coinsurance, **plus** any charges that exceed MAA.

  Exceptions: In the following circumstances, the in-network benefit level applies and you will not be responsible for any amounts in excess of MAA:
  - If we authorize medically necessary services through an out-of-network provider because such services are not available through a preferred provider;
  - When nonemergent services are provided by an out-of-network provider at an in-network health facility, and you were not informed prior to receiving the services that the provider is an out-of-network provider; or
  - When emergency services are provided by an out-of-network provider.

  For further details and requirements, see the *EOC*.
- For some services, prior authorization is necessary to receive full benefits. Please see the "Prior Authorization Requirements" section of this *Disclosure Form* for details.
- To protect you from unusually high medical expenses, there is a maximum amount (or **out-of-pocket maximum**) that you will be responsible for paying in any given year. Once your total payment of the deductibles, copayments and coinsurance equals the out-of-pocket maximum shown on your plan's *SBC*, we will pay 100% of covered expenses. (There are exceptions, see the *SBC* and the *EOC* for details.)

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the SBC. For further information, please refer to the plan's 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 MAA. 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 deductibles, copayments or coinsurance and other applicable amounts set forth in the *EOC*.

- ***MAA 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.

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**

MAA 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.

MAA 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. MAA 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. MAA 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.

- ***MAA 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. Emergency care from an out-of-network provider is subject to the applicable deductible, copayment and/or coinsurance at the preferred provider benefit level. You are not responsible for any amount that exceeds MAA for emergency care.

- ***MAA 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.
- ***MAA 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 MAA may also be subject to other limitations on covered expenses. See the plan's *EOC* for specific benefit limitations, maximums, prior authorization requirements and payment policies that limit the amount Health Net pays for certain covered services and supplies. 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 MAA. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the MAA 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 MAA. 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 MAA 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.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive covered services and supplies, you are responsible for your share of costs as described herein. If you receive services that are not covered by this plan, you are responsible for the entire cost of such services.

*Except in an emergency, when you choose to obtain covered services from an out-of-network provider, you are responsible for your share of cost at the out-of-network benefit level **plus** the amount the provider bills that exceeds MAA.*

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for covered expenses will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required deductible, copayment, coinsurance or amount that exceeds covered expenses.

Please call the Health Net Customer Contact Center at the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to Health Net. Medical and mental health claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

How to File a Claim

For medical or mental health and substance use disorder services, please send a completed claim form within one year of the date of service to:

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain the claim form.

For outpatient prescription drugs, please send a completed prescription drug claim form to:

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain a prescription drug claim form.

Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

REIMBURSEMENT DISCLOSURE

Health Net pays preferred 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 phone number on the back cover.

Facilities

Health care services will be provided at the facilities used by the doctor you choose at the time you seek care. Health Net PPO providers and contracted facilities are listed in the *Health Net PPO Preferred Provider Directory*.

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if, at the time of your enrollment with Health Net, you were receiving care for the conditions listed in the "Continuity of Care upon Termination of Provider Contract" provision immediately below.

Health Net may provide coverage for completion of services from an out-of-network provider at the in-network benefit level, subject to applicable deductible, copayments or coinsurance and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request as soon as reasonably possible. The 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.

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a preferred provider ends, Health Net will make every effort to ensure that care continues. You may request continued care from an out-of-network provider at the in-network benefit level if, at the time of contract termination, you were receiving care from such a provider for the conditions listed below. For providers and hospitals that end their contract with Health Net, a written notice will be provided to members with open prior authorizations within five days after the effective date of the contract termination.

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

The following conditions are eligible for continuation of care:

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

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 to request a copy of the *Continuity of Care Request Form* or of Health Net's continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

Renewing, Continuing or Ending Coverage

RENEWAL PROVISIONS

The contract between Health Net and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage.

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage. More information regarding eligibility for this coverage is provided in your *EOC*.
- **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 plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

Also, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of Benefits" section of this *Disclosure Form* for more information.

TERMINATION OF BENEFITS

The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan's *EOC*.

Termination for Nonpayment of Subscription Charges

Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

Termination for Loss of Eligibility

Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this plan and Health Net ends;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Termination for Cause

Coverage under this Health Net plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a family member;
- 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 report criminal fraud and other illegal acts to the authorities for prosecution.

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 "If You Have a Disagreement with Our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

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

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

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

If You Have a Disagreement with Our Plan

The provisions referenced under this title as described below are applicable to services and supplies covered under this *Disclosure Form*.

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.

MEMBER GRIEVANCE AND APPEALS PROCESS

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

How to file a grievance or appeal

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

You may also write to:

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

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

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

In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net's decision from the Department of Managed Health Care if you meet the eligibility criteria set out in the plan's EOC.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional Plan Benefit Information

The following plan benefits show benefits available with your plan. For a more complete description of copayments, and exclusions and limitations of service, please see the plan's *EOC*.

Behavioral Health Services

You may obtain mental health and substance use disorder services from any behavioral health provider. To obtain care at the in-network benefit level, contact Health Net by calling the Health Net Customer Contact Center at the phone number on the back cover. Health Net will help you identify a nearby participating behavioral health professional with whom you can make an appointment.

Certain services and supplies for mental health and substance use disorders require prior authorization by Health Net in order to be covered. Refer to the "Prior Authorization Requirements" section of this *Disclosure Form* for more details.

Please refer to the plan's *EOC* for a more complete description of covered mental health and substance use disorder services and supplies.

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

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

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

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

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health or substance use disorder from a provider not affiliated with Health Net when you enroll with Health Net, we may temporarily cover services provided by that provider at the in-network benefit level, subject to applicable deductible, copayments or coinsurance and any other exclusions and limitations of this plan.

Your out-of-network 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 to request a copy of the *Continuity of Care Request Form* or of our continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or substance use disorder, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider for covered services to be payable at the in-network benefit level.

WHAT'S COVERED

Please refer to the *SBC* for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies for the treatment of mental health and substance use disorders are subject to the plan's general exclusions and limitations. Please refer to the "Limits of Coverage" section of this *Disclosure Form* for a list of what's not covered under this plan.

This is only a summary. Consult the plan's *EOC* to determine the exact terms and conditions of your coverage.

Prescription Drug Program

Health Net contracts with many major pharmacy chains, supermarket-based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

THE HEALTH NET ESSENTIAL DRUG LIST

This plan uses the Essential Drug List. The Health Net Essential Drug List (or formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net preferred providers that they refer to this 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 ensures that you are receiving a high quality prescription medication that is also of high value.

The Essential Drug List is updated regularly, based on input from the Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Essential Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the Essential Drug List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Contracting PCPs and specialists;
- Medical and scientific publications;
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of Health Net's most current Essential Drug List, please visit our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover. You can search the Essential Drug List to determine whether or not a particular drug is covered.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

How to Request Prior Authorization

Requests for prior authorization may be submitted electronically or by telephone or facsimile. Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. The criteria used for prior authorization are developed and based on input from the P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. 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 decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 365 days of the date of the denial notice. Please refer to the plan's *EOC* for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover;
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
- Write to:

  Health Net Customer Contact Center
  P.O. Box 10348
  Van Nuys, CA 91410-0348

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you may fill it through our convenient prescriptions by mail drug program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications from our network mail-order pharmacy. For complete information, call the Health Net Customer Contact Center at the phone number on the back cover.

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order.

WHAT'S COVERED

Please refer to the SBC for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs - Drugs listed as tier 1 on the Essential Drug List that are not excluded from coverage (include most generic drugs and low-cost preferred brand name drugs);
- Tier 2 drugs – Drugs listed as tier 2 on the Essential Drug List that are not excluded from coverage (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 - Drugs listed on the Essential Drug List as tier 3 (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) - Drugs listed on the Essential Drug List as tier 4 drugs (specialty drugs) (include 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); and
- Preventive drugs and contraceptives.

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of prescription for covered prescription drugs.
- If a prescription drug deductible (per member each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies and preventive drugs and contraceptives are not subject to the deductible. After the deductible is met, the copayment amounts will apply.

- Prescription drug refills are covered, up to a 30-consecutive-calendar-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered. Inhaler spacers and peak flow meters are covered through the pharmacy benefit when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit.
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. 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. Vaginal, oral, transdermal and emergency contraceptives and condoms are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's *EOC* for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for up to a 30-day period.
- Specialty drugs require prior authorization and, upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs. Please refer to the plan's *EOC* for additional information.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

- Allergy serum is covered as a medical benefit;
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;

- 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 drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by federal law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If You Have a Disagreement with Our Plan" section of this *Disclosure Form* for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices and pen needles;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of 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 drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered;
- Except in emergency or urgent care situations, prescription drugs filled by an out-of-network pharmacy are not covered unless your plan's *SBC* provides the out-of-network pharmacy benefit;
- Prescription drugs prescribed by an unlicensed physician;
- Once you have taken possession of medications, replacement of lost, stolen or damaged medications is not covered;
- 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 in the plan's *EOC*; and

- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult the plan's *EOC* to determine the exact terms and conditions of your coverage.

Acupuncture Care Program

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

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

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

- If covered acupuncture services are not available and accessible to you in the county in which you live, you may obtain covered acupuncture cervices from a noncontracted acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered acupuncture services may be subject to verification of medical necessity by ASH Plans except:

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

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

- Auxiliary aids and services are not covered;
- Services provided by an acupuncturist practicing outside California are not covered;
- Diagnostic scanning, MRI, CAT scans or thermography;
- X-rays, laboratory tests, and x-ray second opinions;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, self-help items or services, or physical exercise training;

- Physical therapy services classified as experimental or investigational;
- Experimental or investigational acupuncture services. Only acupuncture services that are noninvestigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Charges for hospital confinement and related services;
- Charges for anesthesia;
- Treatment or services not authorized by ASH Plans or not delivered by a contracted acupuncturist when authorization is required; treatment not delivered by a contracted acupuncturist (except upon referral to a noncontracted acupuncturist approved by ASH Plans); and
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered.

This is only a summary. Consult the plan's *EOC* to determine the exact terms and conditions of your coverage.

Pediatric Vision Care Program

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

WHAT'S COVERED

The pediatric vision services and supplies, as shown below, must be provided by a participating vision provider in order to be covered. To find a participating eyewear dispenser, call the Health Net Vision Program at **1-866-392-6058** or visit our website at www.healthnet.com.

Eyewear Schedule

Professional Services	What You Pay
Routine eye examination with dilation, as medically necessary	$0
Examination for contact lenses	
Standard contact lens fit and follow-up	$0*
Premium contact lens fit and follow-up	$0*

Limitation:

* In accordance with professionally recognized standards of practice, this plan covers one complete vision examination once every calendar year.

Materials (including frames and lenses)	What You Pay
Provider selected frames (one every 12 months)	$0
Standard plastic eyeglass lenses (one pair every 12 months)	$0

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

Optional lenses and treatments including: $0

- UV treatment
- Tint (fashion & gradient & glass-grey)
- Standard plastic scratch coating
- Standard polycarbonate
- Photochromic/Transitions plastic
- Standard and premium anti-reflective coating
- Polarized
- Standard and premium progressive lens
- Hi-index lenses
- Blended segment lenses
- Intermediate vision lenses

Provider selected contact lenses (In lieu of eyeglass lenses) $0

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

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

Medically Necessary Contact Lenses

Coverage of medically necessary contact lenses is subject to medical necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames. Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

High Ametropia exceeding -10D or +10D in meridian powers;

Anisometropia of 3D in meridian powers;

Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses; or

Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

In addition to the limitations described above, the plan does not cover the following:

- Services and supplies provided by a provider who is not a participating vision provider are not covered.
- Charges for services and materials that Health Net determines to be nonmedically necessary are excluded. One routine eye exam with dilation is covered every calendar year and is not subject to medical necessity.
- Plano (nonprescription) lenses are excluded.
- 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.
- Hospital and medical charges of any kind, vision services rendered in a hospital and medical or surgical treatment of the eyes, are not covered.
- A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net participating vision providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

LIABILITY FOR PAYMENT

If you go to a care provider not affiliated with Health Net, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

This is only a summary. Consult the plan's *EOC* to determine the exact terms and conditions of your coverage.

Pediatric Dental Program

WHAT'S COVERED

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen (19) years of age. Benefits are available for medically necessary dental services. You may see either network or non-network providers.

Eligible Dental Expenses

Eligible dental expenses for covered dental services are determined as shown below.

Network benefits: Eligible dental expenses are based on the contracted fee between us and the network provider. You are not responsible for any amount in excess of the contracted fee.

Non-network benefits: Eligible dental expenses are based on Health Net's maximum allowable amounts, which may be more than what non-network providers bill. You are responsible for any amount in excess of the maximum allowable amount. See "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section for more information.

Benefit Summary

The amounts below are the amounts you pay for benefits, and are not subject to any deductibles. The percentage is based on eligible dental expenses. Refer to the *EOC* for a complete listing of covered pediatric dental services, benefit limitations and exclusion.

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.

Benefit Description	Network Benefits	Non-Network Benefits
Diagnostic Benefits	$0	10%
Preventive Benefits	$0	10%
Restorative Benefits	20%	30%
Periodontal Maintenance Services	20%	30%
Endodontics	50%	50%
Periodontics (other than Periodontal Maintenance)	50%	50%
Maxillofacial Prosthetics	50%	50%
Implant Services	50%	50%
Prosthodontics (Removable)	50%	50%
Fixed Prosthodontics	50%	50%
Oral and Maxillofacial Surgery	50%	50%
Medically Necessary Orthodontics	50%	50%

Adjunctive Services	50%	50%

Benefit Limitations:

The limit stated refers to any combination of network benefits and non-network benefits unless otherwise specifically stated. Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Periodic oral evaluations

Periodic oral evaluations are limited to 1 every 6 months.

Prophylaxis

Prophylaxis services (cleanings) are limited to 1 every 6 months.

Fluoride treatment

Fluoride treatment is covered once 1 every 6 months.

Intraoral radiographic images

Intraoral - complete series of radiographic images are limited to once every 24 months. Intraoral – occlusal radiographic images are limited to 2 every 6 months.

Bitewing x-rays

Bitewing x-rays are limited to four radiographic images once every 6 months.

Panoramic film x-rays

Panoramic radiographic images are limited to once every 36 months.

Dental sealant

Dental sealant, per tooth, is limited to the first, second and third permanent molars that occupy the second molar position.

Replacement of a restoration

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such a recurrent caries or fracture, and replacement is medically necessary.

Crowns

Prefabricated crowns – primary teeth are covered once every 12 months. Prefabricated crowns – permanent teeth are covered once every 36 months.

Replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months are covered.

Gingivectomy or gingivoplasty and osseous surgery

Gingivectomy or gingivoplasty and osseous surgery are limited to once per quadrant every 36 months.

Periodontics (other than maintenance)

Periodontal scaling and root planing, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal maintenance

Periodontal maintenance is covered once in a calendar quarter only in the 24-month period following the last scaling and root planing.

Medically necessary orthodontia:

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.

Adjunctive Services:

- Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.
- House/extended care facility calls, once per member per date of service.
- One hospital or ambulatory surgical center call per day per provider per member.
- Teledentistry benefits are limited to twice in a 12-month period.

PEDIATRIC DENTAL EXCLUSIONS

- 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 the *EOC*. See "Dental Services" in the "Exclusions and Limitations" section.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Services that were provided without cost to the member by state government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by their panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or their plan provider is a pedodontist/pediatric dentist. Pediatric dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

This is only a summary. Consult the Evidence of Coverage to determine the exact terms and conditions of your coverage.

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 bąąh 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 ákódoolníłł. 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

FLY017549EH00 (12/17)

Contact Us

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

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