EVIDENCE OF COVERAGE AND PLAN DOCUMENT

A complete explanation of your plan

HMO (Plan [ ])

Important benefit information – please read

Dear Health Net Member:

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

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

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

If you've got a web-enabled smartphone, you've got everything you need to track your health plan details. Take the time to download Health Net Mobile. You'll be able to carry your ID card with you, easily find details about your plan, store provider information for easy access, search for doctors and hospitals, or contact us at any time. It's everything you need to track your health plan details – no matter where you are as long as you have your smartphone handy.

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

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

Thank you for choosing Health Net.

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE HEALTH NET HMO WHOLECARE NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM WHOLECARE NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

Except for Emergency Care, benefits for Physician and Hospital services under this **Health Net HMO WholeCare Network** ("WholeCare Network") plan are only available when you live or work in the WholeCare Network service area and use a WholeCare Network Physician or Hospital. When you enroll in this WholeCare Network plan, you may only use a Physician or Hospital who is in the WholeCare Network and you must choose a WholeCare Network Primary Care Physician. You may obtain ancillary, Pharmacy or Behavioral Health covered services and supplies from any Health Net Participating ancillary, Pharmacy or Behavioral Health Provider.

Obtaining Covered Services under the Health Net HMO WholeCare Network Plan

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY	BEHAVIORAL HEALTH
AVAILABLE FROM	*Only WholeCare Network Hospitals	*Only WholeCare Network Physicians	All Health Net Contracting Ancillary Providers	All Health Net Participating Pharmacies	All Health Net Contracting Behavioral Health providers
*The benefits of this plan for Physician and Hospital services are only available for covered services received from a WholeCare Network Physician or Hospital, except for (1) Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care; (2) referrals to non-WholeCare Network providers are covered when the referral is issued by your WholeCare Network Physician Group; and (3) covered services provided by a non-WholeCare Network provider when authorized by Health Net. Please refer to the "Introduction to Health Net" section for more details on referrals and how to obtain Emergency Care.					

The WholeCare Network service area and a list of its Physician and Hospital providers are shown in the Health Net WholeCare Network Provider Directory. In addition, WholeCare Network Physicians and Hospitals are listed online at our website www.healthnet.com. The WholeCare Network Provider Directory is different from other Health Net Provider Directories. A copy of the Health Net WholeCare Network Provider Directory may be ordered online or by calling Health Net Customer Contact Center at **1-800-361-3366**.

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

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

- Health Net
- Health Net Service Area
- Hospital
- Member Physician, Participating Physician Group, Primary Care Physician, Physician, participating provider, contracting Physician Groups and contracting Providers
- Network
- Provider Directory

Health Net WholeCare Network Alternative Access Standards

The WholeCare Network includes participating primary care and Specialist Physicians, and Hospitals in the WholeCare service area. (CVS MinuteClinic are not available throughout the entire WholeCare Network service area but enrollees have access to all CVS MinuteClinic, where located, regardless of geographic area.). However, WholeCare Members residing in the following zip codes will need to travel as indicated to access a participating PCP and/or receive non-emergency Hospital services.

16– 30 Miles

- **Contra Costa County: 94505** – Discovery Bay (Hospital), **94513** – Brentwood (Hospital), **94514** – Byron (Hospital), **94561** – Oakley (Hospital)
- **Eldorado County: 95614** – Cool (Hospital), **95684** – Somerset (PCP and Hospital), **95726** - Pollock Pines (Hospital)
- **Fresno County: 93606** – Biola (Hospital), **93609** – Caruthers (Hospital), **93630** – Kerman (Hospital), **93656** – Riverdale (Hospital), **93675** - Squaw Valley (Hospital),
- **Madera County: 93610** – Chowchilla (Hospital), **93614** – Coarsegold (Hospital)
- **Marin County: 94937** – Inverness (Hospital), **94956** - Point Reyes Station (Hospital)
- **Merced County: 93620** - Dos Palos (Hospital), **95301** - Atwater (Hospital), **95303** - Ballico (Hospital), **95315** - Delhi (Hospital), **95322** – Gustine (PCP), **95324** - Hilmar (Hospital), **95333** - Le Grand (Hospital), **95334** - Livingston (Hospital), **95374** - Stevinson (Hospital)
- **Napa County: 94558** – Napa (Hospital)
- **Nevada County: 95949** - Grass Valley (Hospital), **95959** - Nevada City (Hospital)
- **Placer County: 95602** – Auburn (Hospital), **95603** – Auburn (Hospital), **95604** – Auburn (Hospital), **95631** - Foresthill (Hospital), **95648** - Lincoln (Hospital), **95681** – Sheridan (Hospital), **95703** - Applegate (Hospital), **95722** - Meadow Vista (Hospital)
- **Sacramento County: 95632** – Galt (Hospital), **95638** - Herald (Hospital), **95683** - Sloughhouse (Hospital), **95693** - Wilton (Hospital)
- **San Joaquin County: 95227** - Clements (Hospital), **95230** - Farmington (Hospital), **95236** - Linden (Hospital), **95304** - Tracy (Hospital), **95320** - Escalon (Hospital), **95376** - Tracy (Hospital), **95377** - Tracy (Hospital), **95385** - Vernalis (Hospital), **95391** - Tracy (Hospital)
- **San Mateo County: 94020** - La Honda (Hospital), **94021** - Loma Mar (Hospital), **94074** - San Gregorio (Hospital)
- **Santa Barbara County: 93434** Guadalupe (PCP), **93440** Los Alamos (PCP), **93454** - Santa Maria (PCP), **93455** - Santa Maria (PCP), **93456** - Santa Maria (PCP), **93458** - Santa Maria (PCP)
- **Santa Cruz County: 95006** - Boulder Creek (Hospital), **95017** - Davenport (Hospital), **95033** - Los Gatos (Hospital)
- **Solano County: 94571** - Rio Vista (PCP and Hospital)
- **Sonoma County: 94923** - Bodega Bay (Hospital), **95421** – Cazadero (PCP and Hospital), **95425** – Cloverdale (Hospital), **95430** - Duncans Mills (Hospital), **95431** – Eldridge (Hospital), **95450** - Jenner (PCP and Hospital)
- **Tulare County: 93219** - Earlimart (Hospital), **93265** - Springville (Hospital), **93271** - Three Rivers (Hospital)
- **Yolo County: 95606** - Brooks (PCP), **95607** - Capay (PCP and Hospital), **95627** - Esparto (PCP and Hospital), **95937** – Dunnigan (PCP and Hospital)

Beyond 30 Miles

- **Fresno County: 93602** – Auberry (Hospital: 39 miles), **93605** - Big Creek (Hospital: 52 miles), **93608** - Cantua Creek (PCP and Hospital: 50 miles), **93622** – Firebaugh (PCP and Hospital: 49 miles), **93627** – Helm (Hospital: 41 miles), **93628** – Hume (PCP and Hospital: 73 miles), **93634** – Lakeshore (PCP and Hospital: 62 miles), **93640** – Mendota (Hospital: 48 miles), **93641** – Miramonte (Hospital: 44 miles), **93664** - Shaver Lake (PCP and Hospital: 57 miles), **93667** – Tollhouse (Hospital: 34 miles), **93668** – Tranquillity (Hospital: 39 miles)
- **Kings County: 93204** – Avenal (Hospital: 43 miles)

- **Madera County: 93601** – Ahwahnee (Hospital: 42 miles), **93604** - Bass Lake (Hospital: 44 miles), **93643** - North Fork (Hospital: 34 miles), **93644** – Oakhurst (Hospital: 65 miles),
- **Merced County: 93635** - Los Banos (Hospital: 44 miles), **95322** – Gustine (Hospital: 34 miles)
- **Napa County: 94558** – Napa (PCP: 59 miles)
- **Santa Barbara County: 93254** - New Cuyama (PCP and Hospital: 75 miles)
- **Sonoma County: 95412** – Annapolis (Hospital and PCP: 43 miles), **95441** - Geyserville (Hospital: 31 miles), **95480** - Stewarts Point (PCP and Hospital: 44 miles), **95497** - Gualala (PCP and Hospital: 53 miles)
- **Tulare County: 93207** - California Hot Springs (PCP and Hospital: 41 miles), **93208** - Camp Nelson (PCP and Hospital: 33 miles), **93260** – Posey (PCP and Hospital: 41 miles), **93262** - Sequoia National Park (Hospital: 51 miles), **93603** - Badger (Hospital: 42 miles)
- **Yolo County: 95637** - Guinda (PCP and Hospital: 32 miles), **95679** - Rumsey (PCP and Hospital: 36 miles)

If you have any questions about the WholeCare Network Service Area, choosing your WholeCare Network Primary Care Physician, how to access Specialist care or your benefits, please contact the Health Net Customer Contact Center at **1-800-361-3366**.

About This Booklet

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

Method of Provider Reimbursement

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

Summary of Plan

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

Please read this *Evidence of Coverage* carefully.

This is not a Federally Qualified Plan

Use of Special Words

Special words used in this *Evidence of Coverage* (EOC) to explain your Plan have their first letter capitalized and appear in "Definitions," Section 900.

The following words are used frequently:

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

Table of Contents

INTRODUCTION TO HEALTH NET

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

The benefits described under this *Evidence of Coverage* do not discriminate on the basis of race, 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.

How to Obtain Care

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

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Customer Contact Center at 1-800-361-3366 to ensure that you can obtain the Health Care Services that you need.

If You Are Enrolled In A Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS *EVIDENCE OF COVERAGE*, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS *EVIDENCE OF COVERAGE*, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact your Employer to determine if you are enrolled in a Plan that is subject to ERISA.

Transition of Care For New Enrollees

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

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the Member's Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;

- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

- a Health Net product with an out of network benefit;
- a different Health Net HMO network product that included Your current provider; or
- another health plan or carrier product.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 900.

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's effective date, and you make the request as soon as reasonably possible. The non-participating 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.

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

Selecting a Primary Care Physician

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

For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician and a list of the participating Primary Care Physicians in the Health Net Service Area are available on the Health Net website at www.healthnet.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.

Selecting a Contracting Physician Group

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

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

Selecting a Participating Mental Health Professional

Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which contracts with Health Net to administer these benefits. When you need to see a Participating Mental Health Professional, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net I.D. card. The Behavioral Health Administrator will help you identify a Participating Mental Health

Professional, a participating independent Physician or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for Mental Disorders and Chemical Dependency may require prior authorization by the Behavioral Health Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged. Please refer to the "Mental Disorders and Chemical Dependency" provision in "Covered Services and Supplies," Section 500 for a complete description of Mental Disorders and Chemical Dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

Specialists and Referral Care

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

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

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

Standing Referral to Specialty Care for Medical and Surgical Services

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

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

Changing Contracting Physician Groups

You may transfer to another contracting Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 400.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Deductible or Copayment described in "Schedule of Benefits and Copayments," Section 200. However, you are completely financially responsible for medical care that the contracting Physician Group does not provide or authorize except for Medically Necessary care provided in a legitimate emergency. You are also financially responsible for care that this Plan does not cover.

Questions

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

Timely Access to Non-Emergency Health Care Services

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

Please contact Health Net at the number shown on your Health Net I.D. Card, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered Health Care Services in a timely manner.

Definitions Related to Timely Access to Non-Emergency Health Care Services

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

Triage or Screening Waiting Time is the time it takes to speak by telephone with a doctor, nurse, or other qualified health care professional who is trained to screen or triage a Member who may need care.

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

Scheduling Appointments with Your Primary Care Physician

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

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

- **PCP appointments**: within 10 business days of request for an appointment.
- **Urgent care appointment with PCP**: within 48 hours of request for an appointment.
- **Routine Check-up/Physical Exam**: within 30 business days of request for an appointment.

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Psychiatrist (Behavioral Health Physician) appointment:** within 10 business days of request for an appointment.
- **A therapist or social worker, non-Physician appointment:** within 10 business days of request for an appointment.
- **Urgent appointment for mental health visit:** within 48 hours of request for an appointment.
- **Non-life threatening behavioral health emergency:** within 6 hours of request for an appointment.

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

Scheduling Appointments with a Specialist for Medical and Surgical Services

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

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

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

- **Specialist appointments:** within 15 business days of request for an appointment.
- **Urgent care appointment:** with a Specialist or other type of provider that needs approval in advance – within 96 hours of request for an appointment.

Scheduling Appointments for Ancillary Services

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

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

- **Ancillary Service appointment:** within 15 business days of request for an appointment.
- **Urgent care appointment for services that need approval in advance:** within 96 hours of request for an appointment.

Canceling or Missing Your Appointments

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

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

As a Health Net Member, when you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the Triage and/or Screening option to these services. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions. As a Health Net Member, you have access to triage or screening service, 24 hours per day, 7 days per week.

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

Emergency and Urgently Needed Care

Health Net uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. Health Net applies the prudent layperson standard to evaluate the necessity of medical services which a Member accesses in connection with a condition that the Member perceives to be an emergency situation. Please refer to "Emergency Care" in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care." Please refer to the following information for a description of how to access your emergency benefits. Additional information is also located in the "Schedule of Benefits and Copayments" section.

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

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

If your situation is not so severe: Call your Primary Care Physician or Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or, if you cannot call them or you need medical care right away, go to the nearest medical center or Hospital.

If you are unsure of whether an emergency medical condition exists, you may call your Physician Group or Primary Care Physician for assistance.

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

Except in an emergency or other urgent medical circumstances, the covered services of this Plan must be performed by your Physician Group or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group.

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

Urgently Needed Care within a 30-mile radius of your Physician Group and all Non-Emergency Care must be performed by your Physician Group or authorized by them in order to be covered. These services, if performed by others outside your Physician Group, will not be covered unless they are authorized by your Physician Group.

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care (including care outside of California) may be performed by your Physician Group or another provider when your circumstances require it. Services by other providers will be covered if the facts demonstrate that you required Emergency or Urgently Needed Care. Authorization is not mandatory to secure coverage. See the "Definitions Related to Emergency and Urgently Needed Care" section below for the definition of Urgently Needed Care.

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

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

After your medical problem (including Severe Mental Illness and Serious Emotional Disturbances of a Child) no longer requires Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered Follow-Up Care.

***Follow-Up Care** services must be performed or authorized by your Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or it will not be covered.*

***Follow-up Care after Emergency Care at a Hospital that is not contracted with Health Net:** If you are treated for Emergency Care at a Hospital that is not contracted with Health Net, Follow-up Care must be authorized by Health Net (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or it will not be covered. If, once your Emergency medical condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the non-contracted Hospital must contact Health Net to obtain timely authorization. If Health Net determines that you may be safely transferred to a Hospital that is contracted with Health Net and you refuse to consent to the transfer, the non-contracted Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your Emergency condition is stable. Also, if the non-contracted Hospital is unable to determine the contact information at Health Net in order to request prior authorization, the non-contracted Hospital may bill you for such services.*

Definitions Related To Emergency And Urgently Needed Care

The following terms are located in "Definitions," Section 900, but they are being repeated here for your convenience.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child) and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes air and ground ambulance and ambulance transport services provided through the "**911**" emergency response system.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- 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 his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, 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.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the drug less any required Copayment shown in "Schedule of Benefits and Copayments," Section 200. You will have to pay for the Prescription Drug when it is dispensed.

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

Note

The Prescription Drugs portion of "Exclusions and Limitations," Section 600 and the requirements of the Essential Rx Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy.

Pediatric Vision Services

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

Pediatric Dental Services

Emergency pediatric dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a reasonably prudent layperson possessing average knowledge of dentistry to believe that immediate care is needed.

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

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

Acupuncture Services

If you require Emergency Acupuncture Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Acupuncture Services are covered Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system, or causing Pain, or Nausea which manifests itself by acute symptoms of sufficient severity such that a reasonable layperson with no special knowledge of health or medicine or acupuncture, could reasonably expect that a delay of immediate attention could result in any of the following:

- Place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Decrease the likelihood of maximum recovery.

ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

You may receive Emergency Acupuncture Services from any acupuncturist. ASH Plans will not cover any services as Emergency Acupuncture Services unless the acupuncturist rendering the services can show that the services in fact were Emergency Acupuncture Services. You must receive all other covered Acupuncture Services from an acupuncturist under contract with ASH Plans ("Contracted Acupuncturist") or from a non-Contracted Acupuncturist only upon a referral by ASH Plans.

Because ASH Plans arranges only Acupuncture Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling **"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 that requires an emergency response.

SCHEDULE OF BENEFITS AND COPAYMENTS

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

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

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to "Out-of-Pocket Maximum," Section 300, for more information.

For certain services and supplies under this Plan, as set out in this schedule, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that covered expenses exceed the Deductible.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center

	Copayment
Use of emergency room (facility and professional services)	$[ ]
Use of urgent care center (facility and professional services)	$[ ]

Copayment Exceptions

- If you are admitted to a Hospital as an inpatient directly from the emergency room or urgent care center, the emergency room or urgent care center Copayment will not apply.
- If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)

Office Visits

	Copayment
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group	$[ ]
Specialist consultation	$[ ]
Visit to CVS MinuteClinic*	$[ ]
Primary Care Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$[ ]
Specialist visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$[ ]
Vision (ages 19 and older) or hearing examination (for diagnosis or treatment)**	$[ ]
Annual physical examination***	Not Covered

Notes

Self-referrals are allowed for Obstetrician and Gynecological services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" portion of "Covered Services and Supplies," Section 500.)

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

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

**See "Pediatric Vision Services (birth through age 18)" for details regarding pediatric vision care services for ages younger than 19.

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

Preventive Care Services

	Copayment
Preventive Care Services	$0

Notes

Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support and supplies, and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Covered Services and Supplies," Section 500, for details.

If You receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$[ ]

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$[ ]
Allergy injection services	$[ ]
Allergy serum	$[ ]
Immunizations for occupational purposes or foreign travel	Not Covered
Other immunizations (non-Preventive Care Services)	$[ ]
Injections (excluding Infertility)	
Office based injectable medications (per dose)	$[ ]
Self-injectable drugs (for each prescription; up to a 30-day maximum per prescription)**	[ ]%

Notes

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

Injections for the treatment of Infertility are described below in the "Infertility Services" section.

** Self -injectable drugs (other than insulin) are considered Specialty Drugs, which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Please refer to the "Prescription Drugs" subsection of "Covered Services and Supplies," Section 500 for additional information.

Rehabilitation and Habilitation Therapy

	Copayment
Physical therapy	$[ ]
Occupational therapy	$[ ]
Speech therapy	$[ ]
Pulmonary rehabilitation therapy	$[ ]
Cardiac rehabilitation therapy	$[ ]
Habilitative therapy	$[ ]

Notes

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation and Habilitation Therapy" of "Exclusions and Limitations," Section 600.

Care for Conditions of Pregnancy

	Copayment
Prenatal care and preconception visits	$[ ]
Postnatal office visit	$[ ]
Specialist consultation regarding pregnancy	$[ ]
Newborn care office visit (birth through 30 days)	$[ ]
Physician visit to the mother or newborn at a Hospital	$[ ]
Normal delivery, including cesarean section	$[ ]
Complications of pregnancy	See note below***
Genetic testing of fetus	$[ ]
Circumcision of newborn (birth through 30 days)****	$[ ]

Notes

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full. See “Preventive Care Services” above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to “Preventive Care Services” and “Pregnancy” under “Covered Services and Supplies,” Section 500.

***Applicable Copayment requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment will apply.

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

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male	$[ ]
Reversal of sterilization	Not Covered

Notes

The diagnosis, evaluation and treatment of Infertility are described below in the "Infertility Services" section.

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Sterilization of females and women’s contraception methods and counseling, as supported by HRSA guidelines, are covered under “Preventive Care Services” in this section.

Infertility Services

	Copayment
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	Not Covered

Other Professional Services

	Copayment
Surgery	$[ ]
Assistance at surgery	$[ ]
Administration of anesthetics	$[ ]

Chemotherapy ..... $[ ]
Radiation therapy ..... $[ ]
Laboratory services ..... $[ ]
Diagnostic imaging (including x-ray) services ..... $[ ]
CT, SPECT, MRI, MUGA and PET ..... $[ ]
Medical social services ..... $[ ]
Patient education ..... $[ ]
Nuclear medicine (use of radioactive materials) ..... $[ ]
Renal dialysis ..... $[ ]
Organ, tissue, or stem cell transplants ..... $[ ]
Infusion therapy in a home, outpatient or office setting* ..... [ ]%

Notes

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

*Infusion therapy is limited to a maximum of 30 days for each supply of injectable Prescription Drugs and other substances, for each delivery.

Medical Supplies

Copayment

Durable Medical Equipment, nebulizers including face masks and tubing ..... [ ]%
Orthotics (such as bracing, supports and casts) ..... [ ]%
Diabetic equipment* ..... [ ]%
Diabetic footwear ..... [ ]%
Prostheses (internal or external)** ..... [ ]%
Blood or blood products $0
Drugs for the treatment of hemophilia*** ..... [ ]%

Notes

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services” in this section. For additional information, please refer to the "Preventive Care Services" provision in “Covered Services and Supplies,” Section 500.

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

*Corrective Footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in "Covered Services and Supplies," Section 500.

**Includes coverage of ostomy and urological supplies. See “Ostomy and Urological Supplies” portion of “Covered Services and Supplies.”

***Drugs for the treatment of hemophilia are considered self-injectable drugs and covered as a Specialty Drug under the Prescription Drug benefit.

Home Health Care Services

Copayment

Home health care services ..... $[ ]

Limitation

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

Hospice Services

Copayment

Hospice care ..... $[ ]

Ambulance Services

	Copayment
Ground ambulance	$[ ]
Air ambulance	$[ ]

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$[ ] per admission

Notes

Inpatient care for Infertility is described above in the "Infertility Services" section.

The above Copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Copayment for inpatient Hospital services will apply.

Outpatient Facility Services

	Copayment
Outpatient facility services (other than surgery)	[ ]%
Outpatient surgery (surgery performed in a Hospital only)	$[ ]

Notes

Outpatient care for Infertility is described above in the "Infertility Services" section.

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

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

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

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

Outpatient Surgical Centers Services

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

Notes

Outpatient care for Infertility is described above in the "Infertility Services" section.

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

Skilled Nursing Facility Services

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

Mental Disorders and Chemical Dependency Benefits

Severe Mental Illness or Serious Emotional Disturbances of a Child	***Copayment***
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$[ ]
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$[ ]
Physician visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$[ ]
Inpatient services	$[ ] per admission

Other Mental Disorders	***Copayment***
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$[ ]
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	$[ ]
Physician visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$[ ]
Inpatient services	$[ ] per admission

Chemical Dependency	***Copayment***
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$[ ]
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	$[ ]
Physician visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$[ ]
Inpatient services	$[ ] per admission
Detoxification	$[ ] per admission

Exceptions

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

Each group therapy session requires only one half of a private office visit Copayment.

Notes

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

Prescription Drugs

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

	Deductible and Copayment
Prescription Drug Deductible, required for Brand Name Drugs (per Member, per Calendar Year)	$[ ]

COPAYMENTS

Copayment

Retail Pharmacy (up to a 30 day supply)

Tier I Drugs (Generic Drugs listed in the Essential Rx Drug List) .....$[ ]
Tier II Drugs (preferred Brand Name Drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Health Net Essential Rx Drug List).....$[ ]
Tier III Drugs (non-preferred Brand Name Drugs, drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Health Net Essential Rx Drug List).....$[ ]
Preventive drugs and women's contraceptives $0
Sexual dysfunction drugs (including self-injectable drugs)..... [ ]%
Appetite Suppressants ..... [ ]%

Specialty Drugs (up to a 30 day supply)

Specialty Drugs (provided through a Specialty Pharmacy Vendor) ..... [ ]%

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

Tier I Drugs (Generic Drugs listed in the Essential Drug List).....$[ ]
Tier II Drugs (preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List).....$[ ]
Tier III Drugs (non-preferred Brand Name Drugs, drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List) .....$[ ]
Preventive drugs and women's contraceptives $0

Notes:

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

For information about Health Net's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.

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

Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered Brand Name Drugs are subject to the applicable Prescription Drug Deductible as required for Brand Name Drugs and Copayment for Tier II Drugs or Tier III Drugs or Specialty Drugs.

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

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

Deductible:

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

The amount applied toward your Prescription Drug Deductible for covered Prescription Drugs is Health Net's contracted pharmacy rate or the pharmacy's retail price, whichever is less.

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

COPAYMENTS

Prior Authorization

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Services and Supplies" Section 500 for a description of Prior Authorization requirements or visit our website at www.healthnet.com to obtain a list of drugs that require Prior Authorization.

Copayment Exceptions:

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

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

Preventive Drugs and Women's Contraceptives:

Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member, and are not subject to the Deductible. Covered preventive drugs include over-the-counter drugs and Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Forces A and B recommendations, including smoking cessation drugs. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 500, for additional details.

If a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the Generic and Brand Name Drug. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

Mail Order:

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

Diabetic Supplies:

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

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

Sexual Dysfunction Drugs:

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period. Sexual dysfunction drugs are not available through the mail order program.

Specialty Drugs:

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

Acupuncture Services

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

Office Visits	***Copayment***
New patient examination	$[ ]
Each subsequent visit	$[ ]
Re-examination visit	$[ ]
Second opinion	$[ ]

Note

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

Limitations

Acupuncture services are covered when Medically Necessary.

Pediatric Vision Services (birth through age 18)

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

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

Professional Services	***Copayment***
Routine eye examination with dilation	$[ ]
Examination for Contact Lenses	
Standard contact lens fit and follow-up	up to $[ ]
Premium contact lens fit and follow-up	[ ]% off retail

Limitation:

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

Note:

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

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

Standard contact lens include soft, spherical and daily wear contact lenses.

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

Materials (including frames and lenses)	***Copayment***
Provider selected Frames (one every 12 months)	$[ ]
Standard Plastic Eyeglass Lenses (one pair every 12 months)	$[ ]
• Single vision, bifocal, trifocal, lenticular	
• Glass or plastic	
Optional Lenses and Treatments including:	$[ ]
• UV Treatment	
• Tint (Fashion & Gradient & Glass-Grey)	
• Standard Plastic Scratch Coating	
• Standard Polycarbonate –	
• Photocromatic/Transitions Plastic	
• Standard Anti-Reflective Coating	
• Polarized	
• Standard Progressive Lens	
• Hi-Index Lenses	
• Blended segment Lenses	
• Intermediate vision Lenses	
• Select or ultra-progressive lenses	
Premium Progressive Lenses	$[ ]
Provider selected Contact Lenses (In lieu of eyeglass lenses)	$[ ]

COPAYMENTS

- Extended Wear Disposables: Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
- Daily Wear/Disposables: Up to 3 month supply of daily disposables, single vision spherical contact lenses
- Conventional: 1 pair from selection of provider designated contact lenses
- Medically Necessary*

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

Medically Necessary Contact Lenses:
Coverage of Medically Necessary contact lenses is subject to Medical Necessity, Prior Authorization from Health Net and all applicable exclusions and limitations. See "Vision Services" portion of "Exclusions and Limitations" for details of limitations.

Pediatric Dental Services (birth through age 18)

All of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. Refer to the "Pediatric Dental Services" portion of "Exclusions and Limitations" for limitations on covered pediatric dental services.

If you have purchased a supplemental pediatric dental benefit plan on the Exchange, pediatric dental benefits covered under this plan will be paid first, with the supplemental pediatric dental benefit plan covering non-covered services and or cost sharing as described in your supplemental pediatric dental benefit plan coverage document.

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

Code	Service	Member Co-payment
Diagnostic		
D0120	Periodic oral evaluation – established patient	$[ ]
D0140	Limited oral evaluation - problem focused	$[ ]
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$[ ]
D0150	Comprehensive oral evaluation - new or established patient	$[ ]
D0160	Detailed and extensive oral evaluation – problem focused, by report	$[ ]
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$[ ]
D0180	Comprehensive periodontal evaluation - new or established patient	$[ ]

Code	Service	Member Co-payment
D0210	X-rays Intraoral - complete series (including bitewings)	$[ ]
D0220	X-rays Intraoral - periapical first film	$[ ]
D0230	X-rays Intraoral - periapical each additional film	$[ ]
D0240	X-rays Intraoral - occlusal film	$[ ]
D0250	Extraoral - first film	$[ ]
D0260	Extraoral - each additional film	$[ ]
D0270	X-rays Bitewing - single film	$[ ]
D0272	X-rays Bitewings - two films	$[ ]
D0273	X-rays Bitewings - three films	$[ ]
D0274	X-rays Bitewings - four films	$[ ]
D0277	Vertical Bitewings - 7 to 8 films	$[ ]
D0330	Panoramic film	$[ ]
D0415	Collect Microorganisms cult & and sensitivity	$[ ]
D0425	Caries Susceptibility tests	$[ ]
D0431	Adjunct pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$[ ]
D0460	Pulp vitality tests	$[ ]
D0470	Diagnostic casts	$[ ]
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$[ ]
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$[ ]
D0474	Accession of tissue, gross and microscopic examination, assessment of surgical margins for presence of disease, preparation and transmission of written report	$[ ]
D0601	Caries risk assessment and documentation, with a finding of low risk	$[ ]
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$[ ]
D0603	Caries risk assessment and documentation, with a finding of high risk	$[ ]
D0999	Office visit fee – per visit	$[ ]
Preventive		
D1120	Prophylaxis - child	$[ ]
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$[ ]
D1208	Topical application of fluoride	$[ ]
D1310	Nutritional counseling for control of dental disease	$[ ]
D1320	Tobacco counseling for the control and prevention of oral disease	$[ ]

COPAYMENTS

Code	Service	Member Co-payment
D1330	Oral hygiene instructions	$[ ]
D1351	Sealant - per tooth	$[ ]
D1352	Prevent resin rest in mod to high risk patients	$[ ]
D1510	Space maintainer - fixed - unilateral	$[ ]
D1515	Space maintainer - fixed - bilateral	$[ ]
D1520	Space maintainer - removable - unilateral	$[ ]
D1525	Space maintainer - removable - bilateral	$[ ]
D1550	Re-cementation of space maintainer	$[ ]
D1555	Removal of fixed space maintainer	$[ ]
Restorative		
D2140	Amalgam - one surface, primary or permanent	$[ ]
D2150	Amalgam - two surfaces, primary or permanent	$[ ]
D2160	Amalgam - three surfaces, primary or permanent	$[ ]
D2161	Amalgam - four or more surfaces, primary or permanent	$[ ]
D2330	Resin-based composite - one surface, anterior	$[ ]
D2331	Resin-based composite - two surfaces, anterior	$[ ]
D2332	Resin-based composite - three surfaces, anterior	$[ ]
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$[ ]
D2390	Resin-based composite crown, anterior	$[ ]
D2391	Resin-based composite - one surface, posterior (permanent tooth)	$[ ]
D2392	Resin-based composite - two surfaces, posterior (permanent tooth)	$[ ]
D2393	Resin-based composite - three surfaces, posterior (permanent tooth)	$[ ]
D2394	Resin-based composite - four or more surfaces, posterior (permanent tooth)	$[ ]
D2510	Inlay - metallic - one surface	$[ ]
D2520	Inlay - metallic - two surfaces	$[ ]
D2530	Inlay - metallic - three or more surfaces	$[ ]
D2542	Onlay - metallic - two surfaces	$[ ]
D2543	Onlay - metallic - three surfaces	$[ ]
D2544	Onlay - metallic - four or more surfaces	$[ ]
D2610	Inlay – porcelain/ceramic – 1 surface	$[ ]
D2620	Inlay – porcelain/ceramic – 2 surfaces	$[ ]
D2630	Inlay – porcelain/ceramic – 3 or more surfaces	$[ ]
D2642	Onlay – porcelain/ceramic – 2 surfaces	$[ ]
D2643	Onlay – porcelain/ceramic – 3 surfaces	$[ ]

Code	Service	Member Co-payment
D2644	Onlay – porcelain/ceramic – 4 or more surfaces	$[ ]
D2650	Inlay – resin based composite – 1 surface	$[ ]
D2651	Inlay – resin based composite – 2 surfaces	$[ ]
D2652	Inlay – resin based composite – 3 or more surfaces	$[ ]
D2662	Onlay – resin based composite – 2 surfaces	$[ ]
D2663	Onlay – resin based composite – 3 surfaces	$[ ]
D2664	Onlay – resin based composite – 4 or more surfaces	$[ ]
Crowns - Single Restorations Only		
D2710	Crown – Resin-based composite (indirect)	$[ ]
D2712	Crown – 3/4 resin-based composite (indirect)	$[ ]
D2720	Crown – Resin with high noble metal	$[ ]
D2721	Crown – Resin with predominantly base metal	$[ ]
D2722	Crown – Resin with noble metal	$[ ]
D2740	Crown - porcelain/ceramic substrate	$[ ]
D2750	Crown - porcelain fused to high noble metal	$[ ]
D2751	Crown - porcelain fused to predominantly base metal	$[ ]
D2752	Crown - porcelain fused to noble metal	$[ ]
D2780	Crown - 3/4 cast high noble metal	$[ ]
D2781	Crown - 3/4 cast predominantly base metal	$[ ]
D2782	Crown - 3/4 cast noble metal	$[ ]
D2783	Crown - 3/4 porcelain/ceramic	$[ ]
D2790	Crown - full cast high noble metal	$[ ]
D2791	Crown - full cast predominantly base metal	$[ ]
D2792	Crown - full cast noble metal	$[ ]
D2794	Crown - titanium	$[ ]
D2910	Recement inlay, onlay, or partial coverage restoration	$[ ]
D2915	Recement cast or prefabricated post and core	$[ ]
D2920	Recement crown	$[ ]
D2921	Re-attachment of tooth fragment, incisal edge or cusp	$[ ]
D2930	Prefabricated stainless steel crown - primary tooth	$[ ]
D2931	Prefabricated stainless steel crown - permanent tooth	$[ ]
D2932	Prefabricated Resin Crown	$[ ]
D2933	Prefabricated Stainless steel crown resin window	$[ ]
D2934	Prefabricated Esthetic coated Stainless steel	$[ ]

COPAYMENTS

Code	Service	Member Co-payment
D2940	Sedative filling	$[ ]
D2941	Interim therapeutic restoration – primary dentition	$[ ]
D2950	Core buildup, including any pins	$[ ]
D2951	Pin retention - per tooth, in addition to restoration	$[ ]
D2952	Cast post and core in addition to crown, indirectly fabricated	$[ ]
D2953	Each additional indirectly fabricated cast post - same tooth	$[ ]
D2954	Prefabricated post and core in addition to crown	$[ ]
D2955	Post removal	$[ ]
D2957	Each additional prefabricated post – same tooth	$[ ]
D2960	Labial veneer (resin based) – chairside	$[ ]
D2962	Labial veneer (porcelain laminate)	$[ ]
D2970	Temporary crown	$[ ]
D2971	Additional procedures to construct new crown under existing partial dental framework	$[ ]
D2980	Crown repair, by report	$[ ]
D2981	Inlay repair necessitated by restorative material failure	$[ ]
D2982	Onlay repair necessitated by restorative material failure	$[ ]
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	$[ ]
D3120	Pulp cap - indirect (excluding final restoration)	$[ ]
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$[ ]
D3221	Pupal debri primary and permanent teeth	$[ ]
D3222	Partial Pulpotomy for apexogenesis	$[ ]
D3230	Pulpal therapy - anterior, primary tooth	$[ ]
D3240	Pulpal therapy - posterior, primary tooth	$[ ]
D3310	Anterior (excluding final restoration)	$[ ]
D3320	Bicuspid (excluding final restoration)	$[ ]
D3330	Molar (excluding final restoration)	$[ ]
D3331	Treatment of root canal obstruction; non-surgical access	$[ ]
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$[ ]
D3333	Internal root repair of perforation defects	$[ ]
D3346	Retreatment of previous root canal therapy - anterior	$[ ]
D3347	Retreatment of previous root canal therapy - bicuspid	$[ ]

Code	Service	Member Co-payment
D3348	Retreatment of previous root canal therapy - molar	$[ ]
D3351	Apexification/recalcification - initial visit	$[ ]
D3352	Apexification/recalcification - interim	$[ ]
D3353	Apexification/recalcification - final visit	$[ ]
D3355	Pulpal regeneration – initial visit	$[ ]
D3356	Pulpal regeneration – interim medicament replacement	$[ ]
D3357	Pulpal regeneration – completion of treatment	$[ ]
D3410	Apicoectomy/periradicular surgery - anterior	$[ ]
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$[ ]
D3425	Apicoectomy/periradicular surgery - molar (first root)	$[ ]
D3426	Apicoectomy/periradicular surgery (each additional root)	$[ ]
D3427	Periradicular surgery without apicoectomy	$[ ]
D3430	Retrograde filling - per root	$[ ]
D3450	Root amputation - per root	$[ ]
D3910	Surgical procedure for isolation of tooth with rubber dam	$[ ]
D3920	Hemisection (including any root removal), not including root canal therapy	$[ ]
D3950	Canal preparation and fitting of preformed dowel or post	$[ ]
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4245	Apically positioned flap	$[ ]
D4249	Clinical crown lengthening - hard tissue	$[ ]
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces - per quadrant	$[ ]
D4263	Bone replacement graft – first site in quadrant	$[ ]
D4264	Bone replacement graft – each additional site in quadrant	$[ ]
D4270	Pedicle soft tissue graft procedure	$[ ]
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$[ ]
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$[ ]

COPAYMENTS

Code	Service	Member Co-payment
D4341	Periodontal scaling and root planing - four or more teeth - per quadrant	$[ ]
D4342	Periodontal scaling and root planing - one to three teeth - per quadrant	$[ ]
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$[ ]
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	$[ ]
D4910	Periodontal maintenance	$[ ]
D4920	Unscheduled dressing change	$[ ]
Prosthodontics		
D5110	Complete denture - maxillary	$[ ]
D5120	Complete denture - mandibular	$[ ]
D5130	Immediate denture - maxillary	$[ ]
D5140	Immediate denture - mandibular	$[ ]
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$[ ]
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$[ ]
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$[ ]
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$[ ]
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$[ ]
D5226	Madibular partial denture – flexible base (including any clasps, rests and teeth)	$[ ]
D5281	Remove Uni Part Denture – 1 PC cast metal	$[ ]
D5410	Adjust complete denture - maxillary	$[ ]
D5411	Adjust complete denture - mandibular	$[ ]
D5421	Adjust partial denture - maxillary	$[ ]
D5422	Adjust partial denture - mandibular	$[ ]
D5510	Repair broken complete denture base	$[ ]
D5520	Replace missing or broken teeth - complete denture (each tooth)	$[ ]
D5610	Repair resin denture base	$[ ]
D5620	Repair cast framework	$[ ]
D5630	Repair or replace broken clasp	$[ ]
D5640	Replace broken teeth - per tooth	$[ ]
D5650	Add tooth to existing partial denture	$[ ]
D5660	Add clasp to existing partial denture	$[ ]
D5670	Replace all teeth & acrylic framework maxillary	$[ ]
D5671	Replace all teeth & acrylic framework mandibular	$[ ]

Code	Service	Member Co-payment
D5710	Rebase complete maxillary denture	$[ ]
D5711	Rebase complete mandibular denture	$[ ]
D5720	Rebase maxillary partial denture	$[ ]
D5721	Rebase mandibular partial denture	$[ ]
D5730	Reline complete maxillary denture (chairside)	$[ ]
D5731	Reline complete mandibular denture (chairside)	$[ ]
D5740	Reline maxillary partial denture (chairside)	$[ ]
D5741	Reline mandibular partial denture (chairside)	$[ ]
D5750	Reline complete maxillary denture (laboratory)	$[ ]
D5751	Reline complete mandibular denture (laboratory)	$[ ]
D5760	Reline maxillary partial denture (laboratory)	$[ ]
D5761	Reline mandibular partial denture (laboratory)	$[ ]
D5820	Interim partial denture (maxillary)	$[ ]
D5821	Interim partial denture (mandibular)	$[ ]
D5850	Tissue conditioning, maxillary	$[ ]
D5851	Tissue conditioning, mandibular	$[ ]
D5863	Overdenture – complete maxillary	$[ ]
D5864	Overdenture – complete mandibular	$[ ]
D5865	Overdenture – partial maxillary	$[ ]
D5866	Overdenture – partial mandibular	$[ ]
D5999	Denture duplication	$[ ]
Prosthodontics (Fixed)		
D6205	Pontic – indirect resin-based composite	$[ ]
D6210	Pontic - cast high noble metal	$[ ]
D6211	Pontic - cast predominantly base metal	$[ ]
D6212	Pontic - cast noble metal	$[ ]
D6214	Pontic - titanium	$[ ]
D6240	Pontic - porcelain fused to high noble metal	$[ ]
D6241	Pontic - porcelain fused to predominantly base metal	$[ ]
D6242	Pontic - porcelain fused to noble metal	$[ ]
D6245	Pontic - porcelain/ceramic	$[ ]
D6250	Crown - porcelain fused to high noble metal	$[ ]
D6251	Crown - porcelain fused to predominantly base metal	$[ ]
D6252	Crown - porcelain fused to noble metal	$[ ]

Code	Service	Member Co-payment
D6600	Inlay – porcelain/ceramic, 2 surfaces	$[ ]
D6601	Inlay – porcelain/ceramic, 3 or more surfaces	$[ ]
D6602	Inlay – cast high noble metal, 2 surfaces	$[ ]
D6603	Inlay – cast high noble metal, 3 or more surfaces	$[ ]
D6604	Inlay – cast predominantly base metal, 2 surfaces	$[ ]
D6605	Inlay – cast predominantly base metal, 3 ore more surfaces	$[ ]
D6606	Inlay – cast noble metal, 2 surfaces	$[ ]
D6607	Inlay – cast noble metal, 3 or more surfaces	$[ ]
D6608	Onlay – porcelain/ceramic, 2 surfaces	$[ ]
D6609	Onlay – porcelain/ceramic, 3 or more surfaces	$[ ]
D6610	Onlay – cast high noble metal 2 surfaces	$[ ]
D6611	Onlay – cast high noble metal 3 or more surfaces	$[ ]
D6612	Onlay – cast predominantly base metal 2 surfaces	$[ ]
D6613	Onlay – cast predominantly base metal 3 or more surfaces	$[ ]
D6614	Onlay – cast noble metal 2 surfaces	$[ ]
D6615	Onlay – cast noble metal 3 or more surfaces	$[ ]
D6624	Inlay titanium	$[ ]
D6634	Onlay titanium	$[ ]
D6710	Crown – indirect resin-based composite	$[ ]
D6720	Crown – resin with high noble metal	$[ ]
D6721	Crown – resin predominantly base metal – denture	$[ ]
D6722	Crown –resin with noble metal	$[ ]
D6740	Crown – porcelain/ceramic	$[ ]
D6750	Crown – porcelain fused to high noble metal	$[ ]
D6751	Crown –porcelain fused to predominantly base metal	$[ ]
D6752	Crown – porcelain fused to noble metal	$[ ]
D6780	Crown - 3/4 cast high noble metal	$[ ]
D6781	Crown - 3/4 cast predominantly base metal	$[ ]
D6782	Crown - 3/4 cast noble metal	$[ ]
D6783	Crown - 3/4 porcelain/ceramic-denture	$[ ]
D6790	Crown - full cast high noble metal	$[ ]
D6791	Crown - full cast predominantly base metal	$[ ]
D6792	Crown - full cast noble metal	$[ ]
D6794	Crown - titanium	$[ ]

Code	Service	Member Co-payment
D6930	Recement fixed partial denture	$[ ]
D6940	Stress breaker	$[ ]
D6980	Fixed partial denture repair, by report	$[ ]
Oral Surgery		
D7111	Extraction, coronal remnants - deciduous tooth	$[ ]
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$[ ]
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$[ ]
D7220	Removal of impacted tooth - soft tissue	$[ ]
D7230	Removal of impacted tooth - partially bony	$[ ]
D7240	Removal of impacted tooth - completely bony	$[ ]
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$[ ]
D7250	Surgical removal of residual tooth roots (cutting procedure)	$[ ]
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	$[ ]
D7280	Surgical access exposure of an unerupted tooth	$[ ]
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$[ ]
D7285	Biopsy of oral tissue - hard (bone, tooth)	$[ ]
D7286	Biopsy of oral tissue - soft (all others)	$[ ]
D7288	Brush biopsy – trans epithelial sample collection	$[ ]
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$[ ]
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$[ ]
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$[ ]
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$[ ]
D7410	Excision of benign lesion up 1/25 cm	$[ ]
D7411	Excision of benign lesion greater than 1.25 cm	$[ ]
D7412	Excision of benign lesion, complicated	$[ ]
D7450	Removal of benign odontogenic cyst up to 1.25 cm	$[ ]
D7451	Removal of benign odontogenic cyst greater than 1.25 cm	$[ ]
D7460	Removal of benign nonodontogenic cyst up to 1.25 cm	$[ ]
D7461	Removal of benign nonodontogenic cyst greater than 1.25 cm	$[ ]
D7471	Removal of lateral exocytosis	$[ ]
D7472	Removal of torus palatines	$[ ]
D7473	Removal of torus mandibularis	$[ ]
D7485	Surgical reduction of osseous tuberosity	$[ ]

COPAYMENTS

Code	Service	Member Co-payment
D7510	Incision and drainage of abscess - intraoral soft tissue	$[ ]
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$[ ]
D7520	Incision and drainage of abscess – extra oral soft tissue	$[ ]
D7521	Incision and drainage of abscess – extra oral soft tissue - complicated	$[ ]
D7910	Suture of recent small wounds up to 5 cm	$[ ]
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$[ ]
D7963	Frenuloplasty	$[ ]
D7970	Excision of hyperplastic tissue – per arch	$[ ]
D7971	Excision of pericoronal gingiva	$[ ]
D7972	Surgical reduction of fibrous tuberosity	$[ ]
D7999	Unspecified oral surgery procedure, by report	$[ ]
Orthodontics		
	Medically Necessary Banded Case	$[ ]
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8660	Pre-orthodontic treatment visit	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$[ ]
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$[ ]
D9211	Regional block anesthesia	$[ ]
D9212	Trigeminal division block anesthesia	$[ ]
D9215	Local anesthesia	$[ ]
D9220	Deep sedation/general anesthesia - first 30 minutes	$[ ]
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$[ ]
D9230	Analgesia, anxiolytics, inhalation of nitrous oxide	$[ ]
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$[ ]
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$[ ]
D9248	Non-intravenous conscious sedation	$[ ]
D9310	Consultation - diagnostic service provided by dentist or physician (other than practitioner providing treatment)	$[ ]
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$[ ]
D9440	Office visit - after regularly scheduled hours	$[ ]

Code	Service	Member Co-payment
D9450	Case presentation, detailed and extensive treatment planning	$[ ]
D9930	Treatment of complications – post surgery	$[ ]
D9940	Occlusal guard by report	$[ ]
D9951	Occlusal adjustment - limited	$[ ]
D9952	Occlusal adjustment – complete	$[ ]
D9972	External bleaching – per arch	$[ ]
D9999	Broken appointment	$[ ]

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

OUT-OF-POCKET MAXIMUM

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

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

The OOPM amounts for this Plan are:

One Member ..... $[ ]

Family (two or more Members) ..... $[ ]

Exception to OOPM

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

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

How the OOPM Works

Keep a record of your payment for covered services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the Customer Contact Center at the telephone number shown on your Health Net ID Card for instructions.

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

You must notify Health Net when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for payments for covered services and supplies as proof of Copayments made.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

The covered services and supplies of this Plan are available to the following individuals as long as they either work or live in the Health Net Service Area and meet any additional eligibility requirements of the Group:

- Subscriber: The principal Member (employee).
- Spouse: The Subscriber's lawful spouse as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner as defined in "Definitions," Section 900.)
- Children: The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren and wards, as defined in the following provision).
- Wards: Children for whom the Subscriber or his or her spouse is a court-appointed guardian.

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

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

Age Limit for Children

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

Disabled Child

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

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

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

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

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

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

How to Enroll for Coverage

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

Employee

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

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

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

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

Eligible employees who enroll in this Plan are called Subscribers.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse (and your spouse's eligible children) within 60 days of the date of marriage. Coverage begins either on the date of marriage or on the first day of the calendar month following the date of marriage, according to the rules established by your Group.

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

Coverage begins either on the date the Domestic Partnership is filed or formed, or on the first day of the calendar month following the date the Domestic Partnership is filed or formed depending on your Group's eligibility rules.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child by the 60th day.

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

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

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

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

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

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

In Hospital on Your Effective Date

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

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

Totally Disabled on Your Effective Date

Generally, under the federal Health Insurance Portability and Accountability Act, Health Net cannot deny You benefits due to the fact that You are totally disabled on your Effective Date. However, if upon your Effective Date you are totally disabled and pursuant to state law you are entitled to an extension of benefits from your prior group

health plan, benefits of this Plan will be coordinated with benefits payable by your prior group health plan, so that not more than 100% of covered expenses are provided for services rendered to treat the disabling condition under both plans.

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

Late Enrollment Rule

Health Net's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for this group coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" provision above.) For time limits for enrolling individuals who become eligible as a dependent outside the Open Enrollment Period, see "Newly Acquired Dependents" provision above. See also "Exceptions to Late Enrollment Rule" below.

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic enrollment forms or phone enrollments are deemed signed when you use your employer's enrollment system to make or confirm changes to your benefit enrollment.

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

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

Exceptions to Late Enrollment Rule

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

1. You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced

If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you if:

- You never received from your employer or signed, a form explaining the consequences of your decision; or
- The signed form exists, but cannot be produced as evidence of your informed decision.

2. You Do Not Enroll Because of Other Coverage and Later the Other Coverage Is Lost

If you declined coverage in this Plan and you stated on the form that the reason you were not enrolling was because of coverage through another group health plan and coverage is or will be lost for any of the following reasons, the late enrollment rule will not apply to you.

- The subscriber of the other plan has ceased being covered by that other plan (except for either failure to pay premium contributions or a "for cause" termination such as fraud or misrepresentation of an important fact).
- Loss of coverage because of termination of employment or reduction in the number of hours of employment.
- Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area.
- Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service area, and no other benefit package is available to the individual.
- The other plan is terminated and not replaced with other group coverage.
- The other employer stops making contributions toward employee's or dependent's coverage.

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

3. You Lose Eligibility from an Access for Infants and Mothers Program (AIM) or a Medi-Cal Plan

If you become ineligible and lose coverage under the Access for Infants and Mothers Program (AIM) or Medi-Cal, you and/or your dependent(s) will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If you and/or your dependent(s) wait longer than 60 days to enroll, you and/or your dependent(s) may not enroll until the next Open Enrollment period.

4. Multiple Health Plans

If you are enrolled as a dependent in a health plan (not Health Net) and the Subscriber, during open enrollment, chooses a different plan (such as moving from an HMO plan to a fee-for-service plan) and you do not wish to continue to be covered by it, you will not be considered a late enrollee should you decide to enroll in this Plan.

5. Court Orders

If a court orders the Subscriber to provide coverage for a spouse (a current spouse, not a former spouse) or orders the Subscriber or enrolled spouse to provide coverage for a minor child through Health Net, that spouse or child will not be treated as a late enrollee.

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

Special Enrollment Rule For Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption or marriage the following rules apply.

If the Employee Is Enrolled in this Plan

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

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

If the Employee Declined Enrollment in this Plan

If you previously declined enrollment in this Plan because of other group coverage, and you gain a new dependent due to childbirth, marriage, adoption or placement for adoption, you can enroll yourself and the dependent within 60 days of birth, marriage, adoption or placement for adoption.

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

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

If you do not enroll yourself, the new dependent and any other family members within 60 days of acquiring the new dependent, you will have to wait until the next Open Enrollment to do so.

The Effective Date of coverage for you and all family members who enroll within 60 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth.
- For marriage, the Effective Date will be either on the date of marriage or the first of the month following the date of marriage, according to the rules established by your Group.
- Regarding adoption, the Effective Date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

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

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

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net," Section 100, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

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

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

Exceptions

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

Effective Date of Transfer

If we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If we receive your request for a transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 1.)

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

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

When Coverage Ends

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

Health Net will issue a Certificate of Creditable Coverage after your coverage is terminated. To request a duplicate Certificate of Creditable Coverage, please contact the Customer Contact Center at the phone number on Your Health Net ID card.

All Group Members

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

Termination for Nonpayment of Subscription Charges

If the Group fails to pay the required subscription charges when due, the Group Service Agreement could be canceled after a 30-day grace period. On or before the subscription charges due date, Health Net will provide your employer notification of the 30-day grace period. The 30-day grace period starts the first day following the last day of paid coverage. During the 30-day grace period, Health Net must continue your coverage under this plan.

If Health Net does not receive payment of the delinquent subscription charges from your employer within the 30-day grace period, coverage will be terminated at the end of the grace period and Health Net will cancel the Group Service Agreement and mail the Subscriber and your employer a Notice Confirming Termination of Coverage.

The Notice Confirming Termination of Coverage will provide you and your employer with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; and (3) the Health Net telephone number you can call to obtain additional information, including whether your employer obtained reinstatement of the Group Service Agreement (Health Net allows one reinstatement during any twelve-month period if the Group requests reinstatement and pays the amounts owed within 15 days of the date of mailing of the Notice Confirming Termination of Coverage).

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

Termination for Loss of Eligibility

Individual Members become ineligible on the date any of the following occurs:

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

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

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

- The Member establishes primary residency outside the Health Net Service Area and does not work inside the Health Net Service Area.

However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area, does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care.

Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by the contracting Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).

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

The Subscriber and all his or her Family Members will become ineligible for coverage at the same time if the Subscriber loses eligibility for this plan.

Termination for Cause

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

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

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

How to Appeal Your Termination

You have the right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "Grievance Procedures" provision in "General Provisions," Section 700 for information about how to appeal Health Net's decision to terminate your coverage.

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

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "Grievance Procedures" provision in "General Provisions," Section 700. If your complaint is decided in your favor, Health Net will reinstate your coverage back to the date of the termination.

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

Coverage Options Following Termination

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

*Please examine your options carefully before declining coverage.***COBRA Continuation Coverage**: Many groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of

1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with your Group to determine if you and your covered dependents are eligible.

- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage. This subject is detailed below in the section titled "Small Employer Cal-COBRA Continuation Coverage."

- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue Group coverage under this *Evidence of Coverage* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

  Choosing Cal-COBRA: If an eligible Member wishes to choose Cal-COBRA Continuation Coverage, he or she must deliver the completed enrollment form (described immediately above) to Health Net by first class mail, personal delivery, express mail, or private courier company. The address appears on the back cover of this Evidence of Coverage.

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

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

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

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

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

  1. If the Member had chosen Cal-COBRA Continuation Coverage through a previous plan provided by his or her current employer and replaced by this plan because the previous policy was terminated, or

  2. If the Member selects this plan at the time of the employer's open enrollment.

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

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

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

1. You have been covered for 36 months from your original COBRA Effective Date (under this or any other plan).*
2. The Member becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Member moves outside the Health Net Service Area.
4. The Member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
5. The Group's Agreement with Health Net terminates. (See "Employer Replaces this Plan.")
6. The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

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

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

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

Small Employer Cal-COBRA Continuation Coverage

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

Definitions

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

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

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

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

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

- Termination of employment for reasons other than gross misconduct. (For individuals who began receiving Cal-COBRA continuation coverage prior to January 1, 2003, 18 months of coverage is available. For individuals who began receiving their Cal-COBRA coverage on or after January 1, 2003, 36 months of coverage is available.)
- Reduction in hours worked. (For individuals who began receiving Cal-COBRA continuation coverage prior to January 1, 2003, 18 months of coverage is available. For individuals who began receiving their Cal-COBRA coverage on or after January 1, 2003, 36 months of coverage is available.)*
- Death of the employee or Subscriber. (36 months of coverage is available.)
- Divorce or legal separation of the enrolled employee from his or her enrolled spouse. (36 months of coverage is available.)
- A dependent child ceases to be a dependent child according to the eligibility rules of the plan. (36 months of coverage is available.)
- A Family Member ceases to be eligible when the employee or Subscriber becomes entitled to Medicare coverage (enrolls in Medicare). (36 months of coverage is available.)

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

Small Employer means an employer that meets the definition of Small Employer as described in Section 1357 of the California Health and Safety Code or Section 10700 of the California Insurance Code. For Small Employer Cal-COBRA Continuation, the following must also be true of the employer:

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

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

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

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

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

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

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

Newborns And Adoptions During Small Employer Cal-COBRA Continuation Coverage: If a child is born to or placed for adoption with the former employee, the child shall have the status of Qualified Beneficiary. This means the child will have the same rights as all other Qualified Beneficiaries. Children who began receiving Cal-COBRA continuation coverage prior to January 1, 2003, could experience a second Qualifying Event during their initial 18 months of Small Employer Cal-COBRA Continuation Coverage. For example, the death of the

Subscriber, would entitle the child to an additional period of coverage. The additional period of coverage would be 18 months. The total period of coverage would be 36 months.

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

Who May Choose Small Employer Cal-COBRA Continuation Coverage?

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

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

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

- Is enrolled in Medicare.
- Is covered by another group health plan that does not contain a pre-existing condition limitation that prevents the individual from receiving the full benefits of such plan.

If the individual is covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, the individual may choose Small Employer Cal-COBRA Continuation Coverage. Coordination of Benefits will apply, and this Small Employer Cal-COBRA plan will be the primary plan.

- Is covered or could become covered by any federal laws regarding continuation of group health plan coverage.
- Fails to notify Health Net of a Qualifying Event according to the requirements described below under "Notify Health Net of Small Employer Cal-COBRA Qualifying Event."
- Fails to submit the initial premium payment in the correct amount as described below under "Payment for Small Employer Cal-COBRA."

Notify Health Net Of Small Employer Cal-COBRA Qualifying Event

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

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

Health Net Will Offer Small Employer Cal-COBRA To Members

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

Choosing Small Employer Cal-COBRA

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

The Member must deliver the enrollment form to Health Net within 60 days of the later of (1) the Qualifying Event or (2) the date he or she was sent a notice from Health Net that he or she has the right to continue Small

Employer Cal-COBRA Continuation Coverage or (3) the date that coverage through the employer plan terminated.

Payment For Small Employer Cal-COBRA

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

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

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

When Does Small Employer Cal-COBRA Continuation Coverage End?

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

- 36 months from the date coverage would ordinarily have ended due to termination of employment for reasons other than gross misconduct for individuals who began receiving their Cal-COBRA continuation coverage prior on or after January 1, 2003 and 18 months for individuals who began receiving their Cal-COBRA continuation coverage prior to January 1, 2003.*
- 36 months from the date coverage would ordinarily have ended due to reduction in hours worked for individuals who began their Cal-COBRA continuation coverage on or after January 1, 2003 and 18 months for individuals who began receiving their Cal-COBRA continuation coverage prior to January 1, 2003.
- For individuals who began receiving Cal-COBRA continuation coverage prior to January 1, 2003, 36 months from the date coverage would ordinarily have ended due to termination of employment for reasons other than gross misconduct or reduction in hours worked, but only if the Qualified Beneficiary was determined by the Social Security Administration to be totally disabled, pursuant to Title II or Title XVI of the Social Security Act and to have been disabled on the date that coverage would have been lost due to the initial Qualifying Event or during the first 30 days of Small Employer Cal-COBRA Continuation Coverage.
- 36 months from the date coverage would ordinarily have ended due to:
    1. Death of the covered employee or Subscriber.
    2. Divorce or separation of the covered employee or Subscriber from his or her spouse.
    3. Loss of dependent status by a covered dependent child.
    4. The Subscriber becomes entitled to Medicare, that is, enrolls in the Medicare program.
- The Member becomes or could become covered, in accordance with any federal laws regarding continuation of group health plan coverage.
- The Member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Small Employer Cal-COBRA."
- The Member becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

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

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

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

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if you lose your Health Net coverage because the Group Service Agreement is discontinued and you are ***totally disabled*** at that time. When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits and Copayments," Section 200, will continue to apply.

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

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

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

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

How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. No extension will be granted unless Health Net receives written certification of such total disability from the Member's Physician Group within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Health Net.

When the Extension Ends

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

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

COVERED SERVICES AND SUPPLIES

You are entitled to receive Medically Necessary services and supplies described below when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a covered service.

Any covered service or supply may require a Copayment or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 200, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 600, before obtaining care.

Medical Services and Supplies

Office Visits

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

CVS MinuteClinic Services

CVS MinuteClinic visits for Preventive Care Services and for the diagnosis and evaluation of minor illnesses or injuries are covered as shown in "Schedule of Benefits and Copayments," Section 200.

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

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

In addition, the CVS MinuteClinic also provides non-preventive care services, such as the evaluation and diagnosis of:

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

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

You will receive a written visit summary at the conclusion of each CVS MinuteClinic visit. With your permission, summaries of your CVS MinuteClinic visit, regardless of visit type, are sent to your Primary Care Physician. If you require a non-emergent referral to a Specialist, you will be referred back to your Primary Care Physician for coordination of such care.

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

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

Certain limitations or exclusions may apply. CVS MinuteClinic may offer some services that are not covered by this Plan. Please refer to the "General Exclusions and Limitations" portion of "Exclusions and Limitations," Section 600, for more information. For additional information about CVS MinuteClinic, please contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card.

Preventive Care Services

The coverage described below shall be consistent with the requirements of the Affordable Care Act (ACA). Preventive Care Services are covered for children and adults, as directed by your Physician, based on the guidelines from the following resources:

- U.S. Preventive Services Task Force Grade A & B recommendations (www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (www.cdc.gov/vaccines/recs/ACIP/)
- Guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services are available through www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- USPSTF and HRSA recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits

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

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the Member. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by Your Physician. Breast pumps can be obtained by calling the Customer Contact Center at the phone number on your Health Net ID card.

Preventive Care Services are covered as shown in "Schedule of Benefits and Copayments," Section 200.

Vision and Hearing Examinations

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 200. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 200.

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

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

Immunizations and Injections

This Plan covers immunizations and injections (including infusion therapy when administered by a health care professional in the office setting), professional services to inject the medications and the medications that are injected. This includes allergy serum. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 200.

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

You will be charged appropriate Copayment as shown in "Schedule of Benefits and Copayments," Section 200.

Surgical Services

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

Surgically Implanted Drugs

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

Transgender Surgery

Transgender surgery and services related to the surgery, that are subject to prior authorization by Health Net are covered. The transgender surgery must be performed by Health Net-qualified provider in conjunction with gender transformation treatment. Beyond the actual surgery, no cosmetic procedures are covered.

As a prerequisite to transgender surgery, the candidate is required to undergo twelve (12) months of hormone therapy. This requirement will be waived if such therapy is contraindicated for clinical reasons for the surgery candidate.

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Home Visit

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

Rehabilitation Therapy
Rehabilitation therapy services (physical, speech, and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 600.

Habilitative Services
Coverage for habilitative services and/or therapy is limited to Medically Necessary services that assist an individual in partially or fully acquiring or improving age-appropriate skills and functioning and that are necessary to address a health condition, to the maximum extent practical, when provided by a Member Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical and mental health conditions or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism, subject to any required authorization from Health Net or your Physician Group. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group and address the skills and abilities needed for functioning in interaction with an individual's environment.

Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

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

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

Clinical Trials
Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net. The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. Services rendered as part of a clinical trial may be provided by a non-participating or participating provider subject to the reimbursement guidelines as specified in the law. Coverage for routine patient care shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health;
- The FDA as an Investigational new drug application;
- The Department of Defense; or
- The Veterans' Administration.

The following definition applies to the terms mentioned in the above provision only.

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

Please refer to "General Exclusions and Limitations" portion of "Exclusions and Limitations," Section 600, for more information.

Pregnancy
Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered. Please refer to "Schedule of Benefits and Copayments," Section 200, for Copayment requirements.

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

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

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

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

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

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

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

Family Planning

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

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Prescribed contraceptives for women are covered as described in the "Prescription Drugs" portion of this "Covered Services and Supplies" section of this Evidence of Coverage.

This Plan also covers Medically Necessary services and supplies for standard fertility preservation treatments, when a cancer treatment may directly or indirectly cause iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment. This benefit is subject to the applicable Copayments shown in "Schedule of Benefits and Copayments," Section 200, as would be required for covered services to treat any illness or condition under this Plan.

Medical Social Services

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

Patient Education

Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered. Your Physician Group will coordinate access to these services.

Home Health Care Services

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

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

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

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See "Definitions," Section 900. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

Custodial Care services and Private Duty Nursing, as described in "Definitions," Section 900 and any other types of services primarily for the comfort or convenience of the Member**,** are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See "Definitions," Section 900.

Outpatient Infusion Therapy

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

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

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

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

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

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

- Non-prescription drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;

- FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Ambulance Services

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

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible and they must authorize the services. Nonemergency ambulance and psychiatric transport van services are covered when Medically Necessary and when your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and when the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services.

Please refer to the "Ambulance Services" provision of "Exclusions and Limitations," Section 600 for additional information.

Hospice Care

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

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

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

Durable Medical Equipment

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

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

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

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

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

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health

Net will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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

We also cover up to two Medically Necessary Contact Lenses per eye (including fitting and dispensing) in any 12-month period to treat conditions of aniridia (missing iris). An aniridia Contact Lens will not be covered if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of "Exclusions and Limitations," Section 600. Please refer to "Schedule of Benefits and Copayments," Section 200 for the applicable Copayment.

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

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

Diabetic Equipment

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

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

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

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

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center.

Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your Member Physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon.

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

Approved travel-related expenses will be reimbursed as follows:

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

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

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

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

Evaluation of potential candidates is subject to prior authorization. In general, more than one evaluation (including tests) at more than one transplant center will not be authorized unless it is Medically Necessary.

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donation, including how to elect to be an organ donor, please contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

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

Renal Dialysis

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

Prostheses

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

Also covered are internally implanted devices such as heart pacemakers.

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

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

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

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

Prostheses are covered as shown under “Medical Supplies” in "Schedule of Benefits and Copayments," Section 200.

Ostomy and Urological Supplies

Ostomy and urological supplies are covered under the “Prostheses” benefit as shown under “Medical Supplies” in “Schedule of Benefits and Copayments,” Section 200, and include the following:

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

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered. However, self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group has authorized and scheduled.

Inpatient Hospital Confinement

Covered services include:

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

Outpatient Hospital Services

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

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

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than Copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Hospital Services" in "Schedule of Benefits and Copayments," Section 200 for more information.

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following:

- Improve function; or
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 600. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

Skilled Nursing Facility

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

- Physician and nursing services;
- Room and board;
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel;
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment;
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide;
- Medical social services;
- Blood, blood products, and their administration;
- Medical supplies;
- Physical, occupational, and speech therapy;
- Behavioral health treatment for pervasive developmental disorder or autism; or
- Respiratory therapy.

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

Benefits are limited to the number of days of care stated in "Schedule of Benefits and Copayments," Section 200.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

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

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

Prescription Drugs

Please read the "Prescription Drugs" portion of "Exclusions and Limitations," Section 600.

You must satisfy the required Prescription Drug Calendar Year Deductible shown in the "Schedule of Benefits and Copayments," Section 200, before benefits for Prescription Drugs become payable by Health Net.

Covered Drugs and Supplies

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to "Exclusion and Limitations," Section 600 of this *Evidence of Coverage* to find out if a particular condition is not covered.

Tier I Drugs (Primarily Generic) and Tier II Drugs (Primarily Brand)

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

Tier III Drugs

Tier III Drugs are Prescription Drugs that are non-preferred Brand Name Drugs, drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List.

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

Please refer to the “Essential Rx Drug List” portion of this section for more details.

Generic Equivalents to Brand Name Drugs

Generic Drugs will be dispensed when a Generic Drug equivalent is available. Brand Name Drugs that have generic equivalents will be dispensed when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, subject to the Copayment requirements described in the “Prescription Drugs” portion of “Schedule of Benefits and Copayments,” Section 200.

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
   A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
   B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Essential Rx Drug List or Prior Authorization by Health Net has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
   A. The American Hospital Formulary Service Drug Information; OR
   B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
      i. The Elsevier Gold Standard’s Clinical Pharmacology.
      ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
      iii. The Thomson Micromedex DrugDex; OR
   C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

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

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

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

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

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential Rx Drug List. Diabetic supplies are also covered including, but not limited, to specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this Section, under "Diabetic Equipment," for additional information. Refer to "Schedule of Benefits and Copayments," Section 200, for details about the supply amounts that are covered and the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

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

Specialty Drugs

Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and usually require close monitoring. These drugs may have limited pharmacy availability or distribution and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously). Specialty Drugs are identified in the Essential Rx Drug List with “SP”. Refer to Health Net’s Essential Rx Drug List on our website at healthnet.com for the Specialty Drugs listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

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

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

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered. Coverage for Compounded Drugs is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Prescription Drugs" portion of this "Covered Services and Supplies" section for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier III Drug Copayment and is subject to Prior Authorization by the Plan and Medical Necessity.

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. These Prescription Drugs are covered for up to the number of doses or tablets specified in the

"Schedule of Benefits and Copayments" section. For information about Health Net's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.

Preventive Drugs and Women's Contraceptives

Preventive drugs, including smoking cessation drugs, and women's contraceptives are covered at no cost to the Member. Covered preventive drugs are over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations, including smoking cessation drugs.

Drugs for the relief of nicotine withdrawal symptoms require a prescription from the treating physician. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com.

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

Over-the-counter preventive drugs and women's contraceptives that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs or contraceptives.

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

For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy. Emergency contraceptives required in conjunction with Emergency Care, as defined under "Definitions," Section 900, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Care as defined.

Appetite Suppressants or Drugs for Body Weight Reduction

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

The Essential Rx Drug List

What Is the Health Net Essential Rx Drug List?

Health Net developed the Essential Rx Drug List to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Health Net contracting Physicians and Specialists that they refer to this List when choosing drugs for patients who are Health Net Members. When your Physician prescribes medications listed in the Essential Rx Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Essential Rx Drug List identifies whether a Generic version of a Brand Name Drug exists and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

You may call the Customer Contact Center at the telephone number on your Health Net ID Card to find out if a particular drug is listed in the Essential Rx Drug List. You may also request a copy of the current List and it will be mailed to you. The current List is also available on the Health Net website at www.healthnet.com.

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

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

- Safety;
- Effectiveness;

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

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

Who Is on the Health Net Pharmacy and Therapeutic Committee and How Are Decisions Made?

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

Prior Authorization Process

Prior Authorization status is included in the Essential Rx Drug List – The List identifies which drugs require Prior Authorization. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net. You may obtain a list of drugs requiring Prior Authorization by visiting our website at www.healthnet.com or call the Customer Contact Center at the telephone number on your Health Net ID card. If a drug is not on the List, your Physician should call Health Net to determine if the drug requires Prior Authorization.

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

Requests for Prior Authorization may be submitted electronically or by telephone or facsimile. Urgent requests from Physicians for authorization are processed 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. Routine requests from Physicians are processed in a timely fashion, not to exceed 2 business days, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

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

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

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

Except as described below under "Nonparticipating Pharmacies and Emergencies" you must purchase covered drugs at a Participating Pharmacy.

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

Up to a 30-consecutive-calendar-day supply is covered for each Prescription Drug Order. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other

standard units. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. If the Health Net ID Card is not available or eligibility cannot be determined:

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

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID Card. After 30 days, Prescription Drugs dispensed by a Non-Participating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in "Definitions," Section 900.

If the above situations apply to you:

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

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

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

Note: The "Prescription Drug" portion of "Exclusions and Limitations," Section 600, of this *Evidence of Coverage* and the requirements of the Essential Rx Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

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

Drugs Dispensed by Mail Order

If your prescription is for a Maintenance Drug, you have the option of filling it through our convenient mail order program. To receive Prescription Drugs by mail send the following to the designated mail order administrator:

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

You may obtain a Prescription Mail Order Form and further information by contacting the Customer Contact Center at the telephone number on your Health Net ID Card.

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

Note: Specialty Drugs and Schedule II narcotic drugs are not covered through our mail order program. Refer to the Prescription Drug portion of the "Exclusions and Limitations" section for more information.

Acupuncture Services

Please read the "Acupuncture Services" portion of "Exclusions and Limitations," Section 600.

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

You may receive covered Acupuncture Services from any Contracted Acupuncturist, and you are not required to pre-designate a Contracted Acupuncturist prior to your visit from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from a Contracted Acupuncturist except that:

- You may receive Emergency Acupuncture Services from any acupuncturist, including a non-Contracted Acupuncturist; and
- If covered Acupuncture Services are not available and accessible to you in the county in which you live, you may obtain covered Acupuncture Services from a non-Contracted Acupuncturist who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered Acupuncture Services require pre-approval by ASH Plans except:

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

The following benefits are provided for Acupuncture Services:

Office Visits

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

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

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive therapy may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.

Second Opinion

If you would like a second opinion with regard to covered services provided by a Contracted Acupuncturist, you will have direct access to any other Contracted Acupuncturist. Your visit to a Contracted Acupuncturist for purposes of obtaining a second opinion will count as one visit, for purposes of any maximum benefit and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Contracted Acupuncturist. However, a visit to a second Contracted Acupuncturist to obtain a second opinion will not count as a visit, for purposes of any maximum benefit, if you were referred to the second Contracted Acupuncturist by another Contracted Acupuncturist (the first Contracted Acupuncturist). The visit to the first Contracted Acupuncturist will count toward any maximum benefit.

Pediatric Vision Services (birth through age 18)

Please read the "Pediatric Vision Benefits" portion of "Exclusions and Limitations," Section 800.

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

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

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

Examination
Routine optometric or ophthalmic vision examinations (including refractions) by a licensed Optometrist or Ophthalmologist, for the diagnosis and correction of vision, up to the maximum number of visits stated in the "Schedule of Benefits and Copayments" section.

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

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

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

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

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

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

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

Medically Necessary Contact Lenses
Coverage for prescriptions for Medically Necessary contact lenses is subject to Medical Necessity, Prior Authorization by Health Net and all applicable exclusions and limitations. Contact Lenses are considered Medically Necessary when at least one of the following conditions apply:

- At least one natural lens is removed through cataract surgery and is not replaced with a lens implant (aphakia);

- Contact Lenses are necessary because of keratoconus, when visual acuity cannot be corrected to 20/40 with the use of spectacles;
- They are necessary because of an isometropia 3 diopters or more, provided visual acuity improves to 20/40 or better in the weaker eye;
- They are necessary because of astigmatism of 3 diopters or more;
- They are necessary because of hyperopia of greater than 7 diopters;
- They are necessary because of myopia of greater than 12 diopters; or
- Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Aniseikonia, Corneal Disorders and Post-traumatic Disorders.

Contact Lenses for Conditions of Aphakia

Special Contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic Contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic Contact Lens if we provided an allowance toward (or otherwise covered) more than six aphakic Contact Lenses for that eye during the same Calendar Year.

Pediatric Dental Services (birth through age 18)

Please read the "Dental Benefits" portion of "Exclusions and Limitations," Section 800.

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

Choice of Provider
When you enroll, you must choose a Selected General Dentist from our network. Please refer to the Directory of Participating Dentists for a complete listing of Selected General Dentists.

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

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

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

We recommend that you take this brochure with you on your appointment, along with the enclosed Schedule of Benefits. Remember, only pediatric dental services listed as covered benefits in the Schedule of Benefits and provided by a Selected General Dentist are covered.

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

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

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

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

Second Opinions

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

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

In addition, your Selected General Dentist may also request a second opinion on your behalf. There is no second opinion consultation charge to you. You will be responsible for the office visit co-payment as listed on your Schedule of Benefits. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If you question the reasonableness or necessity of recommended surgical procedures.

(2) If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

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

Copayments

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

Dental Customer Service

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

Mental Disorders and Chemical Dependency

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

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

In order for a Mental Disorder service or supply to be covered, it must be Medically Necessary and authorized by the Behavioral Health Administrator.

The Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which contracts with Health Net to administer these benefits. When you need to see a Participating Mental Health Professional, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net I.D. card.

Certain services and supplies for Mental Disorders and Chemical Dependency require prior authorization by the Behavioral Health Administrator to be covered. The services and supplies that require prior authorization are:

- Outpatient procedures that are not part of an office visit (for example: psychological testing, outpatient electroconvulsive therapy (ECT), outpatient detoxification, and in-home visits); and
- Inpatient, residential, partial hospitalization and intensive outpatient services.

No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

The Behavioral Health Administrator will help you identify a nearby Participating Mental Health Professional, participating independent Physician or a subcontracted provider association (IPA), within the network and with whom you can schedule an appointment, as discussed in "Introduction to Health Net," Section 100. The designated Participating Mental Health Professional, independent Physician or IPA will evaluate you develop a treatment plan for you and submit that treatment plan to the Behavioral Health Administrator for review. Upon review and authorization (if authorization is required) by the Behavioral Health Administrator or IPA, the proposed services will be covered by this Plan if they are determined to be Medically Necessary.

If services under the proposed treatment plan are determined by the Behavioral Health Administrator to not be Medically Necessary, as defined in “Definitions,” Section 900, services and supplies will not be covered for that condition. However, the Behavioral Health Administrator may direct you to community resources where alternative forms of assistance are available. See “General Provisions,” Section 700 for the procedure to request Independent Medical Review of a Plan denial of coverage. Medically Necessary speech, occupational and physical therapy services are covered under the terms of this Plan, regardless of whether community resources are available.

For additional information on accessing mental health services, visit our website at www.healthnet.com and select the MHN link or contact the Behavioral Health Administrator at the Health Net Customer Contact Center phone number shown on your Health Net I.D. card.

In an emergency, call **“911”** or contact the Behavioral Health Administrator at the Customer Contact Center telephone number shown on your Health Net ID Card before receiving care.

Transition of Care For New Enrollees

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

Your non-Participating Mental Health Professional must be willing to accept the Behavioral Health Administrator’s standard mental health provider contract terms and conditions and be located in the Plan’s service area.

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

The following benefits are provided:

Outpatient Services

Outpatient services are covered as shown in "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits."

Covered services include:

- Outpatient office visits/professional consultation including chemical dependency: Includes outpatient crisis intervention, short-term evaluation and therapy, medication management, drug therapy monitoring, longer-term specialized therapy and individual and group mental health evaluation and treatment.
- Outpatient services other than an office visits/professional consultation including chemical dependency: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Disorder, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization program. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism, as shown in the "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits."
    - The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, or by qualified autism service professionals and paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.
    - A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to the Behavioral Health Administrator.
    - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
    - The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
    - Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Second Opinion

You may request a second opinion when:

- Your Participating Mental Health Professional renders a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of the treatment you have received;
- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition;

- Your Primary Care Physician or a referral Physician is unable to diagnose your condition or test results are conflicting;
- The treatment plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care; or
- If you have attempted to follow the plan of care you consulted with the initial Primary Care Physician or a referral Physician due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact the Behavioral Health Administrator. Participating Mental Health Professionals will review your request in accordance with the Behavioral Health Administrator's second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments.

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

Any service recommended must be authorized by the Behavioral Health Administrator in order to be covered.

Inpatient Services

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered as shown in "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits."

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary SED or SMI services in a Residential Treatment Center are covered except as stated in "Exclusions and Limitations," Section 600.

Detoxification and Treatment for Withdrawal Symptoms

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

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 200.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 200.

Covered services include treatment of:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar disorder (manic-depressive illness);
- Major depressive disorders;
- Panic disorder;
- Obsessive-compulsive disorder;
- Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include

Atypical Autism, in accordance with professionally recognized standards including, but not limited to, the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), as amended to date;

- Autism;
- Anorexia nervosa; and
- Bulimia nervosa.

Transitional Residential Recovery Services

Transitional residential recovery services in a licensed recovery home when approved by the Behavioral Health Administrator are covered.

EXCLUSIONS AND LIMITATIONS

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

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

Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic Health Care Service under applicable law, or is required to be covered by other state or federal law, and is Medically Necessary as defined in "Definitions," Section 900.

General Exclusions and Limitations

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

Ambulance Services

Air and ground ambulance and ambulance transport services are covered as shown in the "Ambulance Services" provision of "Covered Services and Supplies," Section 500.

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

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Care, as defined in “Emergency Care” in the “Definitions” section, were not met, unless authorized by your Physician Group, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies," Section 500; or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

Chiropractic Services

This Plan does not cover chiropractic services, except referred by your Physician Group as shown in the “Schedule of Benefits and Copayments” and “Covered Services and Supplies” sections.

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than Health Care Services, including but not limited to cost of travel or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health Care Services that are specifically excluded from coverage under this *Evidence of Coverage*; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care

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

Custodial Care, as described in "Definitions," Section 900, is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient’s condition or provide for the patient’s comforts or ensure the manageability of the patient.

Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant, physical, speech or occupational therapist or other licensed health care provider.

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

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

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

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of "General Provisions," Section 700, for more information; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500.

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

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

Ineligible Status
This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered, except as specified in "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

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

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

Personal or Comfort Items
This Plan does not cover personal or comfort items.

Unlisted Services
This Plan only covers services or supplies that are specified as covered services or supplies in this *Evidence of Coverage,* unless coverage is required by state or federal law.

Services and Supplies

In addition to the exclusions and limitations shown in the "General Exclusions and Limitations" portion of this section, the following exclusions and limitations apply to services and supplies under the medical benefits and the Mental Disorders and Chemical Dependency benefits.

Annual Physical Examinations
This Plan does not cover annual physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes. An annual physical examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member’s general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization. See “Preventive Care Services” in “Covered Services

and Supplies," Section 500, for information about coverage of examinations that are for preventive health purposes.

Aqua or Other Water Therapy
Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.

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

Biofeedback
Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders such as incontinence and chronic Pain, and as otherwise preauthorized by the Behavioral Health Administrator.

Blood
Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered. Self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group or Health Net has authorized and scheduled.

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See "General Provisions," Section 700, for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Conception by Medical Procedures
Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.
- Services to diagnose, evaluate or treat Infertility.

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

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

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

Then, the following are covered:

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to remove or reduce skin or tissue; or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

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

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

CVS MinuteClinic Services

Services required for the treatment of Emergency Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit. Please refer to "Schedule of Benefits and Copayments," Section 200 for applicable Copayment or Deductible requirements for all other services or supplies not covered under the CVS MinuteClinic benefit.

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

Dental Services

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

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 100, for more information. For urgent or unexpected dental conditions that occur after-hours or on weekends, please refer to the "Pediatric Dental Services" portion of "Introduction to Health Net."
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this *Evidence of Coverage* and will only be covered under the following circumstances (a) Members who are under seven years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- For acupuncture treatment of postoperative dental Pain, but only when Acupuncture Services are covered under this Plan through American Specialty Health Plans of California, Inc. (ASH Plans).

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

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or Orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental

conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD/TMJ disorders are covered if they are Medically Necessary, as described in the “Disorders of the Jaw” provision of this section.

- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 500) or as indicated on the U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations.

Disorders of the Jaw

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

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

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

Durable Medical Equipment

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

- Appliances or devices for comfort or convenience; or luxury equipment or features.
- Exercise equipment.
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.
- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the “Prostheses” provision of “Covered Services and Supplies,” Section 500, and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports related activities.
- Orthotics and Corrective Footwear (except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of "Covered Services and Supplies," Section 500).
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this Plan.

Electro-Convulsive Therapy
Electro-Convulsive therapy is not covered except as authorized by the Behavioral Health Administrator.

Fertility Preservation
Fertility preservation treatments are covered as shown in the "Family Planning" provision in "Covered Services and Supplies," Section 500. However, the following services and supplies are not covered:

- Gamete or embryo storage;
- Use of frozen gametes or embryos to achieve future conception;
- Pre-implantation genetic diagnosis;
- Donor eggs, sperm or embryos; or
- Gestational carriers (surrogates).

Genetic Testing and Diagnostic Procedures
Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Member has no medical indication or family history of a genetic abnormality.

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

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

Infertility Services
This Plan does not cover infertility services (including artificial insemination), including professional services, inpatient and outpatient care, treatment by injection and prescription drugs prescribed for infertility.

Massage Therapy
This Plan does not cover massage therapy, except when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group.

Noncovered Treatments
The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

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

Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment.

In addition, Health Net will cover only those Mental Disorder or Chemical Dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law.

Non-eligible Institutions
This Plan only covers services or supplies provided by a legally operated Hospital, Hospice, Medicare-approved Skilled Nursing Facility or other properly licensed facility specified as covered in this *Evidence of Coverage*. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription are covered only when prescribed by a Physician for the management and treatment of diabetes, for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription drug order is not covered even if a Physician writes a Prescription drug order for such drug, equipment or supply unless listed in the Essential Rx Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s) will only be covered when Prior Authorization is obtained from Health Net.

Nonstandard Therapies

Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered.

For information regarding requesting an Independent Medical Review of a denial of coverage see the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions," Section 700.

Physician Self-Treatment

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

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in "Prescription Drug Benefits" portion of "Covered Services and Supplies," Section 500.

Private Duty Nursing

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

Psychological Testing

Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.

Refractive Eye Surgery

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

Rehabilitation and Habilitation Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contracted physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the Plan or the Member's medical group. The services must be based on a treatment plan authorized as required by the Plan or the Member's medical group. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals. See "General Provisions," Section 900(i) for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

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

Residential Treatment Center
Residential treatment that is not Medically Necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house. This exclusion does not apply when the overnight stay is part of covered care in or a licensed facility providing transitional residential recovery Services covered under the "Mental Disorders and Chemical Dependency" section of “Covered Services and Supplies.”

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

Reversal of Surgical Sterilization
This Plan does not cover services to reverse voluntary, surgically induced sterility.

Services for Educational or Training Purposes
Except for services related to behavioral health treatment for pervasive development disorder or autism are covered as shown in “Covered Services and Supplies,” Section 500, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California. Examples of excluded services include education and training for non-medical purposes such as:

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

Services Not Related To Covered Condition, Illness Or Injury
Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services or supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

State Hospital Treatment
Services in a state Hospital are limited to treatment or confinement as the result of an Emergency or Urgently Needed Care as defined in "Definitions," Section 900.

Surrogate Pregnancy
This Plan covers services for a surrogate pregnancy only when the surrogate is a Health Net Member. When compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision

are subject to the Plan's right to recovery as described in "Recovery of Benefits Paid by Health Net Under A Surrogate Parenting Agreement" in the "Specific Provisions" section of this *Evidence of Coverage.*

Telephone Consultations
Treatment or consultations provided by telephone are not covered.

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

Treatment of Obesity
Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity.

Treatment Related to Judicial or Administrative Proceedings
Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered testing are limited to Medically Necessary covered services.

Unauthorized Services and Supplies
This Plan only covers services or supplies that are authorized by Health Net or the Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders or Chemical Dependency) according to Health Net's or the Behavioral Health Administrator's procedures, except for emergency services.

Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by your Physician Group (medical), the Behavioral Health Administrator (Mental Disorders or Chemical Dependency) or when you require Emergency or Urgently Needed Care.

Vision Therapy, Eyeglasses and Contact Lenses
This Plan does not cover vision therapy, Eyeglasses or Contact Lenses except as specified in "Pediatric Vision Benefits" portion of "Covered Services and Supplies," Section 500. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Prescription Drugs

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

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Additional exclusions and limitations:

Allergy Serum
Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See "Allergy, Immunizations and Injections" portion of "Schedule of Benefits and Copayments," Section 200 and "Immunizations and Injections" portion of "Covered Services and Supplies," Section 500.

Appetite Suppressants or Drugs for Body Weight Reduction
Drugs prescribed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to Prior Authorization from Health Net.

Brand Name Drugs that have Generic Equivalents
Brand Name Drugs that have generic equivalents are not covered without Prior Authorization from Health Net.

Devices
Coverage is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers, and those devices listed under "Diabetic Drugs and Supplies" provisions of "Prescription Drugs" portion of "Covered Services and Supplies," Section 500. No other devices are covered even if prescribed by a Member Physician.

Diagnostic Drugs
Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Dietary or Nutritional Supplements
Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product, are limited to drugs that are listed in the Essential Rx Drug List. Phenylketonuria (PKU) treatment is covered under the medical benefit (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 500).

Drugs Prescribed for the Common Cold
Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed by a Dentist
Drugs prescribed for routine dental treatment are not covered.

Drugs Prescribed for Cosmetic or Enhancement Purposes
Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and, mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Retin-A, Vaniqua, Propecia, or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia.

Food and Drug Administration (FDA)
Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net.

Hypodermic Syringes and Needles
Hypodermic syringes and needles are limited to disposable insulin needles and syringes, and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net's specialty pharmacy vendor under the Medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies," Section 500). All other syringes, devices and needles are not covered.

Self-Injectable Drugs
Self-injectable drugs obtained through a prescription from a Physician are limited to insulin, sexual dysfunction drugs and injections listed on the Essential Rx Drug List. Other self-injectable medications are covered under the medical benefit (see "Immunizations and Injections" portion of "Covered Services and Supplies," Section 500). Surgically implanted drugs are covered under the medical benefit (see "Surgically Implanted Drugs" portion of "Covered Services and Supplies," Section 500).

Irrigation Solutions
Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs
Drugs that are lost, stolen or damaged are not covered. You will have to pay the retail price for replacing them.

Nonapproved Uses
Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see "Off-Label Drugs" provision in "Prescription Drugs" portion of "Covered Services and Supplies," Section 500).

Noncovered Services
Drugs prescribed for a condition or treatment that is not covered by this Plan are not covered. However, the Plan does cover Medically Necessary drugs for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Nonparticipating Pharmacies
Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in "Nonparticipating Pharmacies and Emergencies" provision of "Covered Services and Supplies," Section 500.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes, for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception, as approved by the FDA.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless it is listed in the Essential Rx Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s), will only be covered when Medically Necessary and Prior Authorization is obtained from Health Net.

Physician Is Not a Member Physician

Drugs prescribed by a Physician who is not a Member Physician or an authorized Specialist are not covered, except when the Physician's services have been authorized or because of a medical emergency condition, illness or injury or as specifically stated.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment based on recommendations for use by the FDA or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

Schedule II Narcotic Drugs

Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States.

Sexual Dysfunction Drugs

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction limited to a maximum of 8 doses in any 30 day period.

Unit Dose or "Bubble" Packaging

Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Acupuncture Services

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section also apply to Acupuncture Services.

Note: Services or supplies excluded under the acupuncture benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Services, laboratory tests, X-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Auxiliary Aids
Auxiliary aids and services are not covered. This includes but is not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

Diagnostic Radiology
No diagnostic radiology (including X-rays, magnetic resonance imaging or MRI) is covered.

Drugs
Prescription drugs and over-the-counter drugs are not covered.

Durable Medical Equipment
Durable Medical Equipment is not covered.

Educational Programs
Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Acupuncture Services
Acupuncture care that is (a) investigatory; or (b) an unproven Acupuncture Service that does not meet generally accepted and professionally recognized standards of practice in the acupuncture provider community is not covered. ASH Plans will determine what will be considered Experimental or Investigational.

Hospital Charges
Charges for Hospital confinement and related services are not covered.

Anesthesia
Charges for anesthesia are not covered.

Hypnotherapy
Hypnotherapy, sleep therapy, behavior training and weight programs are not covered.

Non-Contracted Providers
Services provided by acupuncturists who do not contract with ASH Plans are not covered, except with regard to Emergency Acupuncture Services or upon referral by ASH Plans.

Out-of-State Services
Services provided by an acupuncturist practicing outside California are not covered, except with regard to Emergency Acupuncture Services.

X-ray and Laboratory Tests
X-ray and laboratory tests are not covered.

Thermography
The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs
Transportation costs are not covered, including local ambulance charges.

Medically/Clinically Unnecessary Services
Only Acupuncture Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Services Not Within License
Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also sometimes called "ear candling," involves the insertion of one end of a long, flammable cone (the "ear cone") into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of *Qi*

but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

Vitamins
Vitamins, minerals, nutritional supplements or other similar products are not covered.

Pediatric Vision Services (birth through age 18)

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Pediatric Vision Services.

Note: Services or supplies excluded under the vision benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Additional exclusions and limitations:

Non-Participating Providers
This vision plan will **not** cover services and supplies provided by a provider who is not a Participating Vision Provider.

Not-Medically Necessary Services and Materials
Charges for services and Materials that Health Net determines to be non-Medically Necessary services, are excluded. One routine eye examination with dilation is covered every calendar year, and is not subject to Medical Necessity.

Medically Necessary Contact Lenses
Coverage for prescriptions for contact lenses is subject to Medical Necessity, Prior Authorization by Health Net and all applicable exclusions and limitations. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames. See the "Pediatric Vision Services" portions of "Schedule of Benefits and Copayments" and "Covered Services and Supplies" for details.

Medical or Hospital
Hospital and medical charges of any kind, vision services rendered in a Hospital and medical or surgical treatment of the eyes, are not covered.

Loss or Theft
Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this plan.

Orthoptics, Vision Training, etc.
Orthoptics and vision training and any associated testing, subnormal vision aids, plano (non-prescription) lenses, lenses are excluded unless specifically identified as a Covered Service in the "Pediatric Vision Services" portion of "Schedule of Benefits and Copayments" section.

Second Pair
A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

Employment Related
Any services or Materials as a condition of employment (e.g., safety glasses). Noted Exception: If the service is determined to be Medically Necessary, irrespective of whether a condition of employment also requires it, the service is covered.

Medical records
Charges associated with copying or transferring vision records are excluded. Noted Exception: If Health Net's contracting provider terminates, lacks capacity or the enrollee is transferred for other good cause, the enrollee is not required to pay the charges associated with copying or transferring vision records to the participating provider in order to obtain covered services.

Pediatric Dental Services (birth through age 18)

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to pediatric dental services.

Note: Services or supplies excluded under the dental benefits may be covered under your medical benefits portion of this Plan Contract and Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," for more information.

Dentally Necessary services are covered only if performed by the Member's Primary Dentist, unless there is a specialist referral from the Member's Primary Dentist. See "Pediatric Dental Services (birth through age 18)" portion of the "Covered Services and Supplies" section.

Additional exclusions and limitations:

Prophylaxis
Prophylaxis services (cleanings) are limited to two every 12 months.

Fluoride treatment
Fluoride treatment is covered twice in any 12 month period.

Bitewing x-rays
Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

Full mouth x-rays
Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

Panoramic film x-rays
Panoramic film x-rays are limited to once every 24 consecutive months.

Dental Sealant
Dental sealant treatments are limited to permanent first and second molars only.

Periodontal treatments
Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Treatment of Caries
For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered optional.

Restorations of posterior teeth using materials other than amalgam
Composite resin or acrylic restorations in posterior teeth are optional. Amalgam is the Plan benefit. Plan will pay as amalgam.

Replacement of a restoration
Replacement of a restoration is covered only when it is defective, as evidence by conditions such a recurrent caries or fracture, and replacement is Dentally Necessary.

Surgical removal of impacted teeth
The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Retreatments
Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing systems. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Crowns
Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filing. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filing.

Veneers
Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Relines or rebases
Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.

Tissue Conditioning
Tissue conditioning is limited to two per denture.

Stayplates
Stayplates (interim partial dentures) are a benefit only when used as anterior space maintainers for children.

Fixed bridgework
Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person under the age of 19. For children under the age of 19, it is considered optional dental treatment. If performed on a Member under the age of 19, the applicant must pay the difference in cost between the fixed bridge and a space maintainer. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. Fixed bridges are optional when provided in connection with a partial denture on the same arch. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Replacement of existing bridgework
Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.

Partial dentures
Partial dentures will not be replaced within 36 months, unless (1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or (2) The denture is unsatisfactory and cannot be made satisfactory. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

Full upper and/or lower dentures
Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. It a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.

Services which, in the opinion of the attending dentist or Health Net, are not Dentally Necessary
The following services, if in the opinion of the attending dentist or Health Net are not Dentally Necessary, will not be covered:

- Temporomandibular joint treatment (aka "TMJ").
- Elective Dentistry and cosmetic dentistry.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.
- Prescription Medications.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.

- Any procedure of implantation.
- Any Experimental procedure. 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 Plan Contract for your health plan with Health Net for more information.
- General anesthesia or Intravenous/Conscious sedation, except as specified in the medical benefits portion of this Plan Contract and EOC. See "Exclusions and Limitations (Section 800)," "Dental Services."
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member's responsibility. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a Covered Service.
- Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
- Pediatric dental services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

Missed Appointments

Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.

GENERAL PROVISIONS

When the Plan Ends

The Group Service Agreement specifies how long this Plan remains in effect.

If you are totally disabled on the date that the Group Service Agreement is terminated, benefits will continue according to "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

When the Plan Changes

Subject to notification and according to the terms of the Group Service Agreement, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions and eligibility provisions.

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under "Eligibility, Enrollment and Termination" Section 400, "When Coverage Ends" regarding termination for non-payment, Health Net will not provide notice of such changes to Plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to Plan Subscribers.

If you are confined in a Hospital when the Group Service Agreement is modified, benefits will continue as if the Plan had not been modified, until you are discharged from the Hospital.

Form or Content of the Plan: No agent or employee of Health Net is authorized to change the form or content of this Plan. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.

Customer Contact Center Interpreter Services

Health Net's Customer Contact Center has bilingual staff and interpreter services for additional languages to handle Member language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to your health plan in your preferred language. Also, our Customer Contact Center staff can help you find a health care provider who speaks your language. Call the Customer Contact Center number on your Health Net ID card for this free service. Health Net discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available at no charge.

Members' Rights and Responsibilities Statement

Health Net is committed to treating Members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted these Members' rights and responsibilities. These rights and responsibilities apply to Members' relationships with Health Net, its contracting practitioners and providers, and all other health care professionals providing care to its Members.

Members have the right to:

- Receive information about Health Net, its services, its practitioners and providers and Members' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to you;

- Use interpreters who are not your family members or friends;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon on with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

Appeal, complaint or grievance means any dissatisfaction expressed by you or your representative concerning a problem with Health Net, a medical provider or your coverage under this EOC, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net plan;
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-800-361-3366** or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com. You may also file your complaint in writing by sending information to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the Mental Disorders and Chemical Dependency program call MHN Services at **1-888-426-0030**, or write to:

MHN Services
Attention: Appeals & Grievances
P.O. Box 10697
San Rafael, CA 94912

If your concern involves the pediatric vision services, call Health Net **1-866-392-6058** or write to:

Health Net
Attention: Customer Contact Center
P.O Box 8504
Mason, OH 45040-7111

If your concern involves pediatric dental services, call Health Net at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130-0569

If your concern involves the acupuncture program, call the Health Net Customer Contact Center at **1-800-522-0088** or write to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

You must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. Please include all information from your Health Net Identification Card and the details of the concern or problem.

We will:

- Confirm in writing within five calendar days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the Department of Managed Health Care for assistance or to request an independent medical review, or you may initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed Health Care Services from the Department of Managed Health Care (Department) if you believe that Health Care Services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any Health Care Service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

1. (A) Your provider has recommended a Health Care Service as Medically Necessary or

   (B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary

   (C) In the absence of the provider recommendation described in 1.(A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the Health Care Service is not Medically Necessary; and

3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious Pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please call the Customer Contact Center at the telephone number on your Health Net ID card.

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.

2. Your Physician must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by Health Net.

3. Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or, as an alternative, you submit a request for a therapy that, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.

4. You have been denied coverage by Health Net for the recommended or requested therapy.

5. If not for Health Net's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to

request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on your Health Net ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan.)

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-361-3366** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, then 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-HMO-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net,

appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provides for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician or the contracting Physician Group.

  Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.

- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.

- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.

- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-Physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S. the treating Physicians and contracting

Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org). Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

Health Net will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Technology Assessment

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

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

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

Health Net and the health care providers that provide services to you through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident; or
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;

- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, Health Net's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this plan, you also grant Health Net an assignment of your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such medical payments carriers to directly reimburse the Plan on your behalf.

Steps You Must Take

If you are injured because of a responsible party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the responsible parties, any or their insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice HNL's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan; and
- Hold any money that you or your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

How the Amount of Your Reimbursement is Determined

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, Hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and, as summarized below, will be calculated in accordance with California Civil Code, Section 3040, or as otherwise permitted by law.

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.

- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro rated share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

** Reimbursement related to Workers' Compensation benefits, ERISA plans, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Certificate and applicable law.*

Recovery of Benefits Paid by Health Net Under A Surrogate Parenting Agreement

This Plan covers services for a surrogate pregnancy only when the surrogate is a Health Net Member. When compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense.

This Plan will provide benefits for all covered services that you receive through this *Evidence of Coverage*. However, if you receive money or are entitled to receive money for the surrogacy, Health Net or the medical providers retains the right to recover the value of any services provided to you through this *Evidence of Coverage*. Health Net's rights of recovery apply to any and all compensation made to and received by you as part of the surrogate parenting agreement up to the full cost of benefits paid under this Plan that are associated with the surrogate pregnancy.

By accepting benefits under this *Evidence of Coverage*, you acknowledge that Health Net has a right of reimbursement that attaches when we have paid for health care benefits associated with a surrogate pregnancy.

Under California law, Health Net's legal right to reimbursement creates a health care lien on any recovery. You must cooperate with Health Net and the medical providers' efforts to obtain reimbursement, including:

- Informing Health Net of any surrogacy compensation agreement and providing a copy when requested by Health Net;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders;
- Notifying the lienholders immediately upon you or your lawyer receiving the compensation; and
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net You receive for the surrogate pregnancy up to the full cost of benefits paid under the *Evidence of Coverage* that are associated with the surrogate pregnancy.

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be calculated in accordance with California Civil Code, Section 3040, or as otherwise permitted by law.

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital or other health care provider.

All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of this Plan.

The Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees or of Physician Groups, any Physician or Hospital or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of this Plan.

Provider/Patient Relationship
Member Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges
While it is not likely, it is possible that Health Net may be unable to pay a Health Net provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with Health Net. You may be held liable for the cost of services or supplies received from a noncontracting provider if Health Net does not pay that provider.

This provision does not affect your obligation to pay any required Copayment or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability
Health Net will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing or use of any Prescription Drug this Plan covers.

Continuity of Care Upon Termination of Provider Contract
If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other Hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the Effective Date of the contract termination.

In addition, a Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

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

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 900 of this *Evidence of Coverage*.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

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

Contracting Administrators
Health Net may designate or replace any contracting administrator that provides the covered services and supplies of this Plan. If Health Net designates or replaces any administrator and as a result procedures change, Health Net will inform you.

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this *Evidence of Coverage*.

Decision-Making Authority
Health Net has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Coordination of Benefits

The Member's coverage is subject to the same limitations, exclusions and other terms of this Evidence of Coverage whether Health Net is the Primary Plan or the Secondary Plan.

Coordination of benefits (COB) is a process, regulated by law, that determines financial responsibility for payment of allowable expenses between two or more group health plans.

Allowable expenses are generally the cost or value of medical services that are covered by two or more group health plans, including two Health Net Plans.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health plan provides benefits in the form of services rather than cash payments.

Health Net's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between the two HMOs or insurers. However, you may occasionally be asked to provide information about your other coverage.

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions
The following definitions apply to the coverage provided under this Subsection only.

A. "**Plan**"—A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   (1) **"Plan" includes** group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

   (Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits, please refer to "Government Coverage" portion of this "General Provisions," Section 700.)

   (2) **"Plan" does not include** nongroup coverage of any type, amounts of Hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

   Each contract for coverage under (1) and (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan**—The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

   When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits.

C. **Allowable Expense**—This concept means a Health Care Service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides

benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

The following are examples of expenses or services that are **not Allowable Expense**:

(1) If a covered person is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

Exception:

If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

(5) The amount a benefit is reduced by the Primary Plan because of a covered person does not comply with the plan provisions is not an Allowable Expense.

Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

D. **Claim Determination Period**—This is the Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

E. **Closed Panel Plan**—This is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**—This is a parent who has been awarded custody of a child by a court decree. In the absence of a court decree, it is the parent with whom the child resided more than half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among Health Net and other applicable group health Plans by establishing which Plan is primary, secondary and so on.

A. **Primary or Secondary Plan**—The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. **No COB Provision**—A Plan that does not contain a coordination of benefits provision is always primary.

There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a closed Panel Plan to provide out-of-network benefits.

C. **Secondary Plan Performs COB**—A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. **Order of Payment Rules**—The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) vs. Dependent**—The Plan that covers the person other than as a dependent, for example as an employee, Subscriber or retiree, is primary and the Plan that covers the person as a dependent is secondary.

2. **Child Covered By More Than One Plan**—The order of payment when a child is covered by more than one Plan is:
   a. **Birthday Rule**—The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. **Court Ordered Responsible Parent**—If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
   c. **Parents Not Married, Divorced or Separated**—If the parents are not married or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The Plan of the Custodial Parent.
      - The Plan of the spouse of the Custodial Parent.
      - The Plan of the noncustodial parent.
      - The Plan of the spouse of the noncustodial parent.
3. **Active vs. Inactive Employee**—The Plan that covers a person as an employee who is neither laid off nor retired (or his or her dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

   If the other plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D (1) above.
4. **COBRA Continuation Coverage**—If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage**—If the preceding rules do not determine the order or payment, the Plan that covers the Subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
   a. **Two Plans Treated As One**—To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the covered person was eligible under the second within twenty-four hours after the first ended.
   b. **New Plan Does Not Include**—The start of a new Plan does not include:
      (i) A change in the amount or scope of a Plan's benefits.

      (ii) A change in the entity that pays, provides or administers the Plan's benefits.

      (iii) A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).
   c. **Measurement of Time Covered**—The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group Plan, the date the person first became a Member of the Group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.
6. **Equal Sharing**—If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on the Benefits of This Plan

A. **Secondary Plan Reduces Benefits**—When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than 100% of total Allowable Expenses.

B. **Coverage by Two Closed Panel Plans**—If a covered person is enrolled in two or more closed Panel Plans and if, for any reason, including the person's having received services from a non-panel provider, benefits are not covered by one closed Panel Plan, COB shall not apply between that plan and other closed Panel Plans.

   But, if services received from a non-panel provider are due to an emergency and would be covered by both Plans, then both Plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

Health Net may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

Health Net need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give Health Net any facts it needs to apply those rules and determine benefits payable.

Health Net's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If the "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

"Amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Government Coverage

Medicare Coordination of Benefits (COB)

When you reach age 65, you may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Member enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If you are enrolled in Medicare Parts A and Part B, and are not an active employee or your employer group has less than twenty employees, then this Plan will coordinate with Medicare and be the secondary plan. This Plan also coordinates with Medicare if you are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If you are not enrolled in Medicare Part A and Part B, Health Net will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the Covered

Services described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net as required under this *Evidence of Coverage*.

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare Coordination of benefits, unless you are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or

Write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare and Medicaid Services
6325 Security Blvd.
Baltimore, MD 21207

Medi-Cal

Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration

Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers' Compensation

This Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers' Compensation laws.

If you require covered services or supplies and the injury or illness is work-related and benefits are available as a requirement of any Workers' Compensation or Occupational Disease Law, your Physician Group will provide services and Health Net will then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of contracting Physician Groups. Your Physician Group performs or authorizes all care and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Customer Contact Center at the telephone number shown on your Health Net ID Card to obtain claim forms.

If you need to file a claim for emergency services or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

Health Net Commercial Claims
P.O. Box 14702
Lexington, KY 40512

If you need to file a claim for outpatient Prescription Drugs, please send a completed Prescription Drugs claim form to:

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

Please call Health Net Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com to obtain a Prescription Drugs claim form.

If you need to file a claim for Emergency Acupuncture Services, or for other covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with (ASH Plans) within one year after receiving those services. You must use ASH Plans' forms in filing the claim, and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
Attention: Customer Contact Center
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Acupuncture Services, you may call ASH Plans at **1-800-678-9133** or you may write ASH Plans at the address given immediately above.

If you need to file a claim for Emergency Mental Disorders and Chemical Dependency, or for other covered Mental Disorders and Chemical Dependency Services provided upon referral by the Behavioral Health Administrator, MHN Services, you must file the claim with MHN Services within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that it was not reasonably possible to file the claim within one year, and that it was filed as soon as reasonably possible. You must use the CMS (HCFA) - 1500 form in filing the claim, and you should send the claim to MHN Services at the address listed in the claim form or to MHN Services at:

MHN Services
P.O. Box 14621
Lexington, KY 40512-4621

MHN Services will give you claim forms on request. For more information regarding claims for covered Mental Disorders and Chemical Dependency Services, you may call MHN Services at **1-800-444-4281** or you may write MHN Services at the address given immediately above.

If you receive emergency pediatric dental services, you will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. For more information regarding claims for covered pediatric dental services, you may call Health Net at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130

To be reimbursed for emergency pediatric dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement.

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

Circumstances beyond Health Net's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant contracting Physician Group personnel or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See "Emergency and Urgently Needed Care" section under "Introduction to Health Net," Section 100.

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. The *Evidence of Coverage*, however, will be posted electronically on Health Net's website at www.healthnet.com. The Group can opt for the Subscribers to receive the *Evidence of Coverage* online. By registering and logging on to Health Net's website, Subscribers can access, download and print the *Evidence of Coverage*, or can choose to receive it by U.S. mail, in which case Health Net will mail the *Evidence of Coverage* to each Subscriber's address on record.

If the Subscriber or the Group is required to provide notice, the notice should be mailed to the Health Net office at the address listed on the back cover of this *Evidence of Coverage*.

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net and the Behavioral Health Administrator* (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the notice. We will make any revised Notices available on our website, www.healthnet.com. (Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.)

How We May Use And Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health coverage or expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our Plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** In addition, we may disclosure your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you. We can disclosure your protected health information to that entity if it has contracted with us to administer your health care program on its behalf.

  If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.
- **Person(s) Involved in Your Care or Payment for Your Care.** We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted Or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.

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- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Other Uses Or Disclosures that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request your written authorization to use or disclose your protected health information for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.
- **Psychotherapy Notes** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

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Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- **Right To Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information or both; and (3) to whom you want the restrictions to apply.
- **Right To Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

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Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes To This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new Effective Date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Contact The Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, you may send it in writing to:

Address: **Health Net Privacy Office**
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: **1-800-361-3366**
Fax: **1-818-676-8314**
Email: **Privacy@healthnet.com**

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DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by ASH Plan to be Medically Necessary for the treatment of that condition.

Acute Conditions is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the Acute Condition.

American Specialty Health Plans of California, Inc. (ASH Plans) is a specialized health care service plan contracting with Health Net to arrange the delivery of Acupuncture Services through a network of Contracted Acupuncturists.

Behavioral Health Administrator is an affiliate behavioral health services administrator which contracts with Health Net to administer delivery of Mental Disorders and Chemical Dependency services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities. Health Net has contracted with MHN Services to be the Behavioral Health Administrator.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national Database used by Health Net.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Chemical Dependency is alcoholism, drug addiction or other chemical dependency problems.

Chemical Dependency Care Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is licensed to provide Chemical Dependency detoxification services or rehabilitation services.

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Acupuncture services to Members.

Copayment is a fee charged to you for covered services when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 200.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinic also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

CVS MinuteClinic must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the State of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

Deductible is a set amount you pay each Calendar Year for specified covered expenses before Health Net pays any benefits for those covered expenses.

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

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

Dependent includes:

- The Subscriber's lawful spouse, as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined below.)
- The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).

Domestic Partner is, for the purposes of this *Evidence of Coverage*, the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the Subscriber's registered domestic partner who meets all the requirements of Sections 297 or 299.2 of the California Family Code. Your Group allows enrollment of same-sex and opposite-sex domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, so the term "Domestic Partner" also includes your domestic partner who meets your Group's eligibility requirements.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides.

Emergency Acupuncture Services are covered services that are Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculor--skeletal system, or causing Pain or Nausea which manifests itself by acute symptoms or sufficient severity such that a reasonable layperson with no special knowledge of health or medicine or acupuncture, could reasonably expect that a delay of immediate attention could result in any of the following: (1) place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decrease the likelihood of maximum recovery. ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would seek if he or she was having serious symptoms and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes air and ground ambulance and ambulance transport services provided through the **"911"** emergency response system.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- 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 his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, 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.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Emergency Dental Care includes Dentally Necessary services required for: (1) the alleviation of severe pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions. However, payment for Emergency Dental Care rendered will be conditioned on Health Net's subsequent review and determination as to consistency with professionally recognized standards of dental practice and Health Net's dental policies.

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Essential Rx Drug List (also known as **Health Net Essential Rx Drug List, Formulary** or **the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com. Some Drugs in the Essential Rx Drug List require Prior Authorization from Health Net in order to be covered.

Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

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

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions," Section 700, as well as "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for additional information.

Eyeglasses are the combination of Lenses and Frames worn to correct or improve vision.

EyeMed Vision Care, LLC is a contracted vision services provider panel which provides and administers Eyewear benefits through a network of dispensing opticians and optometric laboratories.

Eyewear is either Eyeglasses or Contact Lenses.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a health care provider by the state of California to perform the services, acting within the scope of his/her license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Essential Rx Drug List (also known as **Essential Rx Drug List** or **the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com. Some Drugs in the Essential Rx Drug List require Prior Authorization from Health Net in order to be covered.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members, and provide benefits through approved health plans.

Health Net Vision Program provides Eyewear benefits. The program is administered by EyeMed Vision Care, LLC.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in his or her place of residence that is prescribed by the Member's attending Physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this Plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility exists when any of the following apply to a Member when the Member or the Member's partner has not yet gone through menopause:

- The Member has had regular heterosexual relations on a recurring basis for one year or more without use of contraception or other birth control methods which has not resulted in pregnancy, or when a pregnancy did occur, a live birth was not achieved;
- The Member has been unable to achieve conception after six cycles of artificial insemination; or
- The Physician has diagnosed a medical condition that prevents conception or live birth.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net will decide whether a service or supply is Investigational.

With regard to Acupuncture Services, "Investigational" services are acupuncture care that is investigatory.

Lenses are single vision, bifocal or trifocal prescription Lenses that correct or improve vision.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medically Necessary (or Medical Necessity) means Health Care Services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

With regard to Acupuncture Services, "Medically Necessary" services are Acupuncture Services which are necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

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

Member is the Subscriber or an enrolled Family Member.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group.

Mental Disorders are nervous or mental conditions that meet all of the following criteria:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed in the DSM IV (excluding V Codes) by the American Psychiatric Association.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change Physician Groups at this time.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted or on any date approved by Health Net.

Optometrist is a licensed doctor of optometry (O.D.).

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function;
- To support, align, prevent, or correct a defect or function of an injured or diseased body part;
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in "Out-of-Pocket Maximum," Section 300.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain, and post-operative dental Pain.

Participating Eyewear Dispenser is a licensed retail dispenser of Eyewear that has a contract in effect with EyeMed Vision Care, LLC.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net, to provide Mental Disorder and Chemical Dependency benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Chemical Dependency rehabilitation services.

Participating Dentist is a dentist or dental facility licensed to provide Benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Dentists are set forth in Health Net's Participating Dentist Directory. The names of Participating Dentists and their locations and hours of practice may also be obtained by contacting Health Net's Customer Service Department. This plan does not guarantee the initial or continued availability of any particular Participating Dentist.

Participating Mental Health Professional is a Physician or other professional who is licensed, certified, or otherwise authorized by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Disorder and Chemical Dependency rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Participating Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish such care to Members.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

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

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order, or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the "Preventive Care Services" heading as shown in "Schedule of Benefits and Copayments," Section 200, and "Covered Services and Supplies," Section 500. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- maintain good healt;
- prevent or lower the risk of diseases or illnesses;
- detect disease or illness in early stages before symptoms develop; or
- monitor the physical and mental development in children.

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

Primary Dentist is any Participating Dentist who has the responsibility for providing benefits to Members, maintaining the continuity of patient care, initiating referral for orthodontic care and who is listed in the current Participating Dentist Directory for your area as a Primary Dentist.

Prior Authorization is Health Net's approval process for certain Tier I, Tier II or Tier III Drugs that require pre-approval. Member Physicians must obtain Health Net's Prior Authorization before certain Tier I, Tier II or Tier III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Psychiatric Emergency Medical Condition means a Mental Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and is approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior

Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider, and who meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances of a Child is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*, as amended to date), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with acute conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Specialty Drugs are identified in the Health Net Essential Rx Drug List because they have at least one of the following features:

- Treatment of a chronic or complex disease;
- Require high level of patient monitoring, or support;
- Require specialty handling, administration, unique inventory storage, management and/or distribution;

- Require specialized patient training; or
- Are subject to limited distribution.

Specialty Drugs may be given orally, topically, by inhalation, or by self-injection (either subcutaneously or intramuscularly or intravenously). A list of Specialty Drugs can be found in the Health Net Essential Rx Drug List on our website at healthnet.com or by calling the Customer Contact Center telephone number listed on your Health Net ID card.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this *Evidence of Coverage*. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of his or her family who meet the eligibility requirements of the Group and Health Net.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a Terminal Illness.

Tier I Drugs are Prescription Drugs listed in the Health Net Essential Rx Drug List that are primarily Generic Drugs and are not excluded or limited from coverage.

Tier II Drugs are Prescription Drugs listed in the Health Net Essential Rx Drug List that are primarily Brand Name Drugs and are not excluded or limited from coverage.

Tier III Drugs are Prescription Drugs that are not listed in the Health Net Essential Rx Drug List (previously known as the formulary) or listed as Tier III Drugs in the Essential Rx Drug List and are not excluded or limited from coverage. Some Tier III Drugs require Prior Authorization from Health Net in order to be covered.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

NOTICE OF LANGUAGE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或撥 1-800-522-0088。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi Trung tâm Liên lạc Hội viên của Health Net theo số 1-800-522-0088. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화해 주시거나 Health Net의 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa nakalistang numero sa iyong ID card o sa Customer Contact Center ng Health Net sa 1-800-522-0088. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է Ձեզ ապահովագրում՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

無料の言語サービス。日本語の通訳が書類をお読みします。サービスをご希望の方は、IDカード記載の番号まで、またはHealth Netの顧客コンタクト・センター、1-800-522-0088までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте или в Контактный центр для клиентов компании Health Net (Customer Contact Center) по телефону 1-800-522-0088. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا مرکز تماس مشتریان Health Net به شماره 1-800-522-0088 تماس بگیرید. برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company یا Health Net of California, Inc. صادر شده است.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងថ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនរបស់ Health Net តាមលេខ 1-800-522-0088។ សំរាប់ជំនួយ បន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងច្បាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc. ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago ninaalishí bił hada'dil'ínígíí t'áá shǫǫdí Health Net Na'iilniihí Hane' 'Íłł'įh Bił Haz'ánijį' 1-800-522-0088 hodíilnih.T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ą́ąh naa'nil bibee haz'áanii Health Net Life Insurance Company bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'áchą́ąh naa'nil bił haz'ánígíí bich'į' kohjį' áǫįóóǫįaíǫéą́ęí hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dęę' bikáá'.

Navajo

الخدمات اللغوية المجانية. يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك أو الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

Contact us

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

Customer Contact Center
Large Group:
1-800-400-8987
(for companies with 51 or
more employees)

Optimizer HMO HRA
Dedicated Customer Contact Center:
1-800-431-9059

Small Business Group:
1-800-361-3366
(for companies with 2-50 employees)

Individual & Family Plans:
1-800-839-2172

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)

Telecommunications Device for
the Hearing and Speech Impaired
1-800-995-0852

www.healthnet.com