EVIDENCE OF COVERAGE AND PLAN DOCUMENT

A complete explanation of your plan

SELECT (Plan FS9 -) 572900

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 choose to access this document online through Health Net's secure website at www.healthnet.com. You can also elect to have a hard copy of this *Evidence of Coverage* mailed to you. Please call the telephone number on the back of your Member identification card to request a copy.

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 7:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

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

Thank you for choosing Health Net.

About This Booklet

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

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers under SELECT 1 benefits. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on the 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.

Use of Special Words

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

The following words are used frequently:

- "**You**" or "**Your**" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- "**Employee**" has the same meaning as the word "you" above.
- "**We**" or "**Our**" refers to Health Net.
- "**Subscriber**" means the primary covered person, generally an employee of a Group.
- "**Group**" is the business entity (usually an employer) that contracts with Health Net SELECT to provide this coverage to you.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the medical group the individual Member selected as the source of SELECT 1/HMO covered medical care. This may also refer to the provider of services under SELECT 2/PPO.
- "**Primary Care Physician**" is the individual Physician each Member selected who will provide or authorize covered medical care received under SELECT 1/HMO benefits.
- "**Plan**" and "***Evidence of Coverage*** **(EOC)**" have similar meanings. You may think of these as meaning your Health Net benefits.
- "**Tier**" refers to a benefit option offered in your Health Net SELECT benefits.

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INTRODUCTION TO HEALTH NET

Welcome to the SELECT program, a product of Health Net, a Health Care Service plan regulated by the California Department of Managed Health Care. Health Net SELECT provides three types of coverage: the full protection of a Health Maintenance Organization (HMO) through SELECT 1, the flexibility of a Preferred Provider Organization or PPO Network through SELECT 2 and the traditional indemnity arrangement through SELECT 3. This *Evidence of Coverage* (EOC) will explain the SELECT 1, SELECT 2 and SELECT 3 Tiers that are available to you as a Health Net SELECT Member.

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 under the SELECT 1 level of benefits. 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 call Health Net's Customer Contact Center at 1-800-522-0088 to ensure that you can obtain the Health Care Services that you need.

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

How to Obtain Care SELECT 1 (HMO)

SELECT 1 coverage applies when you or your family receives medical care through a contracting Physician Group. When you enroll in the SELECT Plan, you must select a contracting Physician Group where you want to receive your medical care. That contracting Physician Group will provide or authorize all medical care for SELECT 1 benefits except for Emergency Care or Urgently Needed Care (see below). 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.

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. Please refer to the "Mental Disorders and Chemical Dependency" provision in "Covered Services and Supplies" 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 the 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 the "Eligibility, Enrollment and Termination" section.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible for any required Copayment or Coinsurance described in the "Schedule of Benefits and Copayments – SELECT 1" section. If you receive Covered Services at a contracted SELECT 1 health facility at which, or as a result of which, you receive services provided by a SELECT 3 provider, you will pay no more than the same cost sharing you would pay for the same Covered Services received from a SELECT 1 provider. You are also financially responsible for care this SELECT Plan does not cover.

Timely Access to Care

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with Your Primary Care Physician

When you need to see your Primary Care Physician (PCP), call 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.

How to Obtain Care SELECT 2 (PPO)

SELECT 2 coverage applies when you receive medical care from a Health Net SELECT 2 Preferred Provider listed in the *Health Net Network Directory*. Health Net contracts with these providers to furnish medical services at a reduced cost. Health Net will pass that cost savings to you when you use a Preferred Provider. To obtain a copy of the directory, please contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com.

The SELECT 2 Preferred Provider Network is subject to change. It is your obligation to be sure that the provider you choose is a SELECT 2 Provider with a Health Net agreement in effect. IMPORTANT NOTE: Please be aware that it is your responsibility and in your best financial interest to verify that the health care providers treating you are SELECT 2 Providers, including:

- The Hospital or other facility where care will be given. After verifying that the Hospital or the facility is a SELECT 2 Provider, You should not assume all providers at that Hospital or facility are also SELECT 2 Providers; if you receive services from a SELECT 3 Provider at that Hospital or facility, refer to "How to Obtain Care SELECT 3 (OON)" below for information on how those services are paid.
- The provider you select, or to whom you are referred, at the specific location at which you will receive care. Some providers participate at one location, but not at others.

SELECT 2 Providers may refer Members to SELECT 3 (Out-of-Network) Providers but services are covered at the SELECT 3 level of coverage.

Specialists and Referral Care

In the event that you desire to see a Specialist not affiliated with your selected Physician Group, for care or service you have the option to see one of Health Net's Preferred Providers. Simply find the Specialist you wish to see in the Health Net Preferred Provider Directory and schedule an appointment.

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Your Financial Responsibility

You are responsible for specified Copayments or Coinsurance levels. Note that you will have a higher level of coverage with lower out-of-pocket costs through SELECT 1, as compared with SELECT 2 and SELECT 3.

Furthermore, there is also an advantage in using SELECT 2 over SELECT 3. Providers listed in the *Health Net Network Directory* (SELECT 2) have agreed to accept the Contracted Rate as payment in full. You will never be responsible for amounts billed in excess of Covered Expenses.

You are also completely financially responsible for care this SELECT Plan does not cover.

How to Obtain Care SELECT 3 (OON)

You may also receive medical care from any licensed Out-of-Network Provider or Physician Group. Your option to obtain the benefits in this Evidence of Coverage is referred to as SELECT 3. In this case, however, you lose the protection of contracted rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the definition of Maximum Allowable Amount in the "Definitions" section for details.

Non-emergent services provided by a SELECT 3 Provider at an in-network (SELECT 2) facility will be payable at the SELECT 2 Provider level of coverage, with the same cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount); the cost-sharing and Deductible will accrue to the SELECT 2 Out-of-Pocket Maximum.

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

Specialists and Referral Care

In the event you desire to see a particular Specialist that is not listed in Health Net's Provider Directories, you have the option to seek services from an Out of Network Physician. Simply schedule an appointment with the provider you desire and the services will be reimbursed to you based on the Maximum Allowable Amount and your benefits, once you submit the claims to Health Net.

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

Your Financial Responsibility

You are responsible for an annual Deductible and specified Coinsurance levels, including amounts billed in excess of the Maximum Allowable Amount. You are completely financially responsible for care that this SELECT Plan does not cover.

Additionally, the Out-of-Network Provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net for a determination of what portion of the billed charges is reimbursable to you.

Questions

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

Transition of Care For New Enrollees

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

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

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

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

Emergency and Urgently Needed Care through Your SELECT Plan

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.

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

Except in an emergency or other urgent medical circumstances, the covered services of SELECT 1 must be performed by your Physician Group or authorized by them to be performed by others. In order to qualify for SELECT 1 level benefits, 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 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 at the Tier one level. These services, if performed by others outside your Physician Group, will not be covered at the SELECT 1 level 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 by your Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) to be covered under the SELECT 1 benefit level.*

***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 (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency), Follow-up Care must be authorized by Health Net or it will not be covered. If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the 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

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

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a Nonparticipating Pharmacy, this SELECT Plan will reimburse you for the retail cost of the drug less any required Copayment shown in the "Schedule of Benefits and Copayments – SELECT 1" section. You may have to pay for the Prescription Drug when it is dispensed.

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

Note

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

Chiropractic Services

If you require Emergency Chiropractic Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Chiropractic Services are covered services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain such that a person could reasonably expect that a delay of immediate Chiropractic Services could result in serious jeopardy to your health or body functions or organs. See also the “Definitions” section, “Emergency Chiropractic Services.”

ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic 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 Chiropractic Services from any chiropractor. ASH Plans will not cover any services as Emergency Chiropractic Services unless the chiropractor rendering the services can show that the services in fact were Emergency Chiropractic Services. You must receive all other covered Chiropractic Services from a chiropractor under contract with ASH Plans ("Contracted Chiropractor") or from a non-Contracted Chiropractor only upon a referral by ASH Plans.

Because ASH Plans arranges only Chiropractic 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 – SELECT 1

The following schedule shows the Copayments (fixed dollar and percentage amounts) that you must pay for SELECT 1 covered services and supplies.

Percentages shown below may be referred to as "Coinsurance" and are applied to amounts agreed to in advance by Health Net and the Member's Physician Group or other health care provider.

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

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to the "Out-of-Pocket Maximum- SELECT 1" section for more information.

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

	Copayment
Use of emergency room (facility and professional services)	$50
Use of urgent care center (facility and professional services)	$35

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

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Note:

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

Office Visits

	Copayment
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group	$15
Specialist or specialty care consultation**	$15
Visit to CVS MinuteClinic (for Preventive Care Services)*	$0
Visit to CVS MinuteClinic (for Non-Preventive Care Services)*	$10
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$20
Vision and hearing examination (for diagnosis or treatment, including refractive eye examinations)	$15
Telehealth services through Teladoc	$0

Notes

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

* Specialist referrals following care from CVS MinuteClinic must be obtained through the contracting Physician Group under this SELECT 1 level of benefits. Preventive Care Services through the CVS MinuteClinic are subject to the Copayment shown below under "Preventive Care Services."

**Podiatrist, chiropractor and acupuncturist service may be covered under "Specialist or specialty care consultation" as authorized by your Physician Group.

Preventive Care Services

	Copayment
Preventive Care Services	$0

Notes

Covered services include, but are not limited to, annual preventive physical examinations, immunizations, 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 for details.

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

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Note

The above Copayment applies to professional services only. Care that is rendered in a Hospital is also subject to the applicable facility Copayment. Look under the “Inpatient Hospital Services” heading to determine any additional Copayments that may apply.

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$0
Allergy injection services	$0
Allergy serum	$15
Immunizations for occupational purposes or foreign travel	20%
Injections (except for Infertility)	
Office based injectable medications (per dose)	$0

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.

Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician’s office. If you need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through our contracted Specialty Pharmacy Vendor and bring it with you to the Physician’s office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted Specialty Pharmacy Vendor. Please refer to the "Specialty Drugs (up to a 30 day supply)" portion of this "Schedule of Benefits and Copayments – SELECT 1" section for the applicable Copayment.

Rehabilitation Therapy

	Copayment
Physical therapy	$0
Occupational therapy	$0
Speech therapy	$0
Pulmonary rehabilitation therapy	$0
Cardiac rehabilitation therapy	$0

Notes

These services will be covered when Medically Necessary.

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

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$15
Physician visit to the mother or newborn at a Hospital	$0
Normal delivery, including cesarean section	$0
Complications of pregnancy	See note below***
Genetic testing of fetus	$0
Circumcision of newborn (birth through 30 days)****	$0

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 the "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 the “Covered Services and Supplies” section.

***Applicable Copayment or Coinsurance 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 or Coinsurance will apply.

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

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male	$50

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)	50%

Notes

Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections.

Injections for Infertility are covered only when provided in connection with services that are covered by this Plan.

Refer to the "Family Planning" provision in the "Covered Services and Supplies" section and the "Conception by Medical Procedures" provision of the "Exclusions and Limitations" section for additional information.

If one partner does not have Health Net coverage, Infertility services are covered only for the Health Net Member.

Infertility services (which include GIFT and artificial insemination) and all covered services that prepare the Member to receive this procedure, are covered only for the Health Net Member.

Other Professional Services

	Copayment
Surgery	$0
Assistance at surgery	$0
Administration of anesthetics	$0
Chemotherapy	$0
Radiation therapy	$0
Laboratory services	$0
Diagnostic imaging (including x-ray) services	$0
Medical social services	$0
Patient education*	$0
Nuclear medicine (use of radioactive materials)	$0
Renal dialysis	$0
Organ, tissue or stem cell transplants	$0

Notes

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

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

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

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers, including face masks and tubing	$0
Orthotics (such as bracing, supports and casts)	$0
Diabetic equipment*	$0
Diabetic footwear	$0
Prostheses (internal or external)	$0
Blood or blood products except for drugs used to treat hemophilia, including blood factors***	$0
Hearing aids	$0

Limitation

The Hearing aids Copayment will apply toward the purchase of the hearing aid. Hearing aids are covered to a maximum payment of $1000 every 36 months. Coverage includes repair and maintenance of the hearing aid at no additional charge. The initial hearing exam and fitting are also subject to the vision or hearing examination Copayment. Look under the "Office Visits" heading in this "Schedule of Benefits and Copayments – SELECT 1" section to determine any additional Copayment that may apply. Additional charges for batteries (including the first set) or other equipment related to the hearing aid, or replacement of the hearing aid are not covered.

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 the “Covered Services and Supplies” section.

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

* For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Services and Supplies" section.

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

Home Health Care Services

	Copayment
Copayments are required for home health visits on and after the 31st calendar day of the treatment plan	$15

Hospice Services

	Copayment
Hospice care	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$0

Notes

The above Copayments apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the “Hospital Visits by Physician,” “Care for Conditions of Pregnancy” and “Other Professional Services” headings to determine any additional Copayments that may apply.

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

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

Outpatient Facility Services

	Copayment
Outpatient facility services (other than surgery)	$0
Outpatient surgery (surgery performed in a Hospital or Outpatient Surgical Center only)	$0

Notes

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

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 that is required when these services are performed at your Physician’s office.

Look under the headings for the various services such as office visits, rehabilitation and other professional services to determine any additional 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 or Coinsurance applicable for outpatient facility services.

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

Skilled Nursing Facility Services

	Copayment
Room and board in a semiprivate room with ancillary (additional) services	$0

Limitation

Skilled Nursing Facility services are covered for up to a maximum of 100 days a Calendar Year for each Member.

Notes

The above Copayment is applicable for each admission.

Prescription Drugs

	Copayment

Retail Pharmacy (up to a 30 day supply)

Tier 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary	$5
Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Commercial Formulary	$15
Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 in the Commercial Formulary, drugs indicated as "NF," if approved, drugs not listed in the Commercial Formulary	$30
Lancets	$0
Appetite suppressants	50%
Sexual dysfunction drugs (including self-injectable drugs)	50%
Infertility drugs	50%
Preventive drugs and women's contraceptives	$0

Specialty Drugs (up to a 30 day supply)

Except as listed below, all Specialty Drugs are subject to the applicable Tier 1, 2, or 3 Drug Copayment shown above under "Retail Pharmacy."

Self-injectable drugs and drugs for the treatment of hemophilia, including blood factors, per prescription, maximum of 30 days per prescription	$0

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

Tier 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary	$10
Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Commercial Formulary	$30
Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs	

listed as Tier 3 in the Commercial Formulary, drugs indicated as "NF,"
if approved, drugs not listed in the Commercial Formulary $60
Lancets $0
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 Commercial Formulary, 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 unless a Brand Name Drug is specifically requested by the Physician or the Member, subject to the Copayment requirements specified in the "Copayment Exceptions" provision below.

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

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

Prior Authorization:

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

Copayment Exceptions:

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

If a Generic Drug equivalent is available and a Brand Name Drug is dispensed, then you must pay the following:

- The Tier 1 Drug Copayment, plus; and
- The difference between the cost of the Generic Drug and the Brand Name Drug.

However, if the Prescription Drug Order states "do not substitute," "dispense as written," or words of similar meaning in the Physician's handwriting to indicate Medical Necessity, then you must pay the following:

- The Tier 2 Drug Copayment for Tier 2 Drugs; or
- The Tier 3 Drug Copayment for Tier 3 Drugs.

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. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Prescription Drugs" portion of

the "Covered Services and Supplies" section for additional details. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

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.

Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.

Mail Order

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

Diabetic Supplies:

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

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

Sexual Dysfunction Drugs:

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to quantities as specified in Health Net's Commercial Formulary. For information about Health Net's Commercial Formulary, please call the Customer Contact Center at the telephone number on your ID card. Sexual dysfunction drugs are not available through the mail order program.

Chiropractic Services and Supplies

Chiropractic Services and supplies are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you may obtain chiropractic care by selecting a Contracted Chiropractor from our *ASH Plans Contracted Chiropractor Directory*.

Office Visits	Copayment
New patient examination	$5
Each subsequent visit	$5
Re-examination visit	$5
Second opinion	$5

Note

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

Limitations

Up to 20 Medically Necessary office visits to a Contracted Chiropractor during a Calendar Year are covered.

A visit to a Contracted Chiropractor to obtain a second opinion generally will not count toward the Calendar Year visit limit if you were referred by another Contracted Chiropractor. However, the visit to the first Contracted Chiropractor will count toward the Calendar Year visit limit.

Diagnostic Services	Copayment
X-rays	$0
Laboratory test	$0

Chiropractic Appliances	Copayment
For each appliance	$0

Limitation

Up to a maximum of $50 is covered for each Member during a Calendar Year for covered Chiropractic Appliances.

Mental Disorders and Chemical Dependency Benefits

The Mental Disorders and Chemical Dependency benefits under SELECT 1 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.

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, medication management, drug therapy monitoring)	$15
Outpatient group therapy session	$7.50
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 therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$0
Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Behavioral Health Administrator)	$15
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center	$0
Other Mental Disorders	**Copayment**
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15
Outpatient group therapy session	$7.50

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) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Behavioral Health Administrator) $15

Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Chemical Dependency	**Copayment**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring) $15

Outpatient group therapy session $7.50

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Behavioral Health Administrator) $15

Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Exception

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

Notes

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

The above inpatient services Copayment is applicable for each admission.

OUT-OF-POCKET MAXIMUM- SELECT 1

The SELECT 1 Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for SELECT 1 covered services during a particular Calendar Year, except as described in "Exceptions to SELECT 1 OOPM" below.

Once the total amount of all Copayments or Coinsurance you pay for SELECT 1 covered services and supplies under this *Evidence of Coverage* in any one Calendar Year equals the "SELECT 1 Out-of-Pocket Maximum" amount listed below, no payment for SELECT 1 covered services and benefits may be imposed on any Member, except as described in "Exceptions to SELECT 1 OOPM" below.

OOPM for Medical Benefits

The SELECT 1 OOPM amounts for Medical Benefits, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans) are:

One Member $1,500
Family (three or more Members).....$4,500

OOPM for Outpatient Prescription Drug Benefits

The OOPM amounts for this Plan are:

One Member $2000
Family (three or more Members).....$4000

Any Copayment or Coinsurance paid for covered services received from a SELECT 1 provider will also apply toward the OOPM for SELECT 2 and SELECT 3. Any Copayment or Coinsurance paid for covered services received from a SELECT 2 or SELECT 3 provider will also apply toward the OOPM for SELECT 1.

Exceptions to SELECT 1 OOPM

Your payments for services or supplies that SELECT 1 does not cover will not be applied to the SELECT 1 OOPM amount.

The following Copayments, Deductibles and expenses paid by you for covered services or supplies under this Plan will not be applied to the SELECT 1 OOPM amount:

- Copayments made for Prescription Drug benefits. However, Copayments for peak flow meters and inhaler spacers used for the treatment of asthma and diabetic supplies dispensed through a Participating Pharmacy will be applied to the SELECT 1 OOPM amount. Copayments for self-injectable drugs, which are covered under the medical benefit, will also be applied to the OOPM amount.
- Out-of-pocket costs for prescription drugs exceeding Prescription Drug benefit coverage as described in the “Retail Pharmacies and Mail Order Program” provision of the “Prescription Drugs” subsection of the “Covered Services and Supplies” section and any cost differential between brand/generic medications when dispensing Brand Name Drugs not based on medical necessity.
- Services from a CVS MinuteClinic that are not otherwise covered under this Plan. Please refer to “Exclusions and Limitations,” Section 600 for additional information.

You are required to continue to pay these Deductibles and Copayments listed by the bullets above after the OOPM has been reached.

Note

All Specialty Drugs will be applied to the Pharmacy OOPM.

How the OOPM works

Keep a record of your payment for SELECT 1 covered services and supplies. When the total in a Calendar Year reaches the SELECT 1 OOPM amount shown above, contact Health Net's Customer Contact Center at the telephone number shown on your Health Net ID Card for instructions.

- If an individual Member pays amounts for SELECT 1 covered services and supplies in a Calendar Year that equal the SELECT 1 OOPM amount shown above for an individual Member, no further SELECT 1 payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the SELECT 1 individual OOPM, the remaining enrolled Family Members must continue to pay the SELECT 1 Copayments until either (a) the aggregate of such SELECT 1 Copayments paid by the Family reaches the SELECT 1 Family OOPM or (b) each enrolled Family Member individually satisfies the SELECT 1 individual OOPM.
- If amounts for SELECT 1 covered services and supplies paid for all enrolled Members equal the SELECT 1 OOPM amount shown for a family, no further SELECT 1 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 SELECT 1 OOPM amount may be applied to the family's SELECT 1 OOPM amount. Any amount you pay for SELECT 1 covered services and supplies for yourself that would otherwise apply to your SELECT 1 individual OOPM but exceeds the above stated SELECT 1 OOPM amount for one Member will be refunded to you by Health Net, and will not apply toward your family's SELECT 1 OOPM. Individual Members cannot contribute more than their individual SELECT 1 OOPM amount to the SELECT 1 Family OOPM.

You must notify Health Net when the SELECT 1 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.

SCHEDULE OF BENEFITS AND COPAYMENTS – SELECT 2 AND SELECT 3

The following schedule shows the applicable Coinsurance or Copayments for SELECT 2 and SELECT 3 covered services and supplies.

For certain services and supplies under this Plan, as set out in the 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.

Members receiving services under SELECT 2 have a choice of using any Preferred Provider. If you receive care or services from a Preferred Provider, you will be responsible for either a Copayment or a percentage of the Contracted Rate (Coinsurance). Your Copayment or Coinsurance to be paid is stated after each benefit listed below under the heading "SELECT 2."

Members who use an Out-of-Network Provider, in other words SELECT 3 benefits, will be responsible for the percentage of the Maximum Allowable Amount (Coinsurance) and any amount billed in excess of that charge. Your Coinsurance to be paid is stated after each benefit listed below under the heading "SELECT 3."

In some instances Certification of Covered Expenses will be required or your benefits will be reduced. The benefits requiring Certification will be indicated on this SELECT 2 and SELECT 3 schedule with an asterisk (*). Please see the "Certification Requirement" section for further details.

Deductible

Each Calendar Year, a Member who uses an Out-of-Network provider (SELECT 3) will need to satisfy the medical Deductible amount below before Covered Expenses can be paid under the SELECT 3 Tier.

Any amount exceeding the Maximum Allowable Amount or any other amount not considered a Covered Expense will not be applied toward the Deductible. Any additional Deductible incurred by you as a penalty for receiving non-certified services or expenses incurred under the Prescription Drug benefit, another supplemental benefit or any Noncertification Deductibles, are not applied to your Deductible. Supplemental benefits are benefits additional to those described in the "Medical Services and Supplies" subsection of the "Covered Services and Supplies" section.

If during the Calendar Year, the Members of an enrolled family together incur a Deductible amount equal to the family medical Deductible shown below, no further medical Deductible is required for any enrolled Family Member during the remainder of that Calendar Year.

Covered Expenses incurred under SELECT 3 in the last three months of a Calendar Year, used to satisfy the medical Deductible(s) for that Calendar Year, may also be used to satisfy the medical Deductible(s) for the following Calendar Year.

	SELECT 2	SELECT 3
Member Deductible	No Deductible	$200
Family Deductible	No Deductible	$600
Noncertification Deductible	$250	$250

Copayments and Coinsurance

Non-Emergency or Non-Urgent Care obtained in an Emergency Room or Urgent Care Center

	SELECT 2	SELECT 3
Non-emergency use of emergency room (facility only)	$75	30%
Non-emergency use of urgent care center (facility only)	$50	30%
Professional services	10%	30%

Notes

Please refer to the Emergency or Urgently Needed Care sections in the introduction and the "Schedule of Benefits and Copayments – SELECT 1" section for an explanation of your Emergency and Urgently Needed Care benefits. Emergency and Urgently Needed Care is covered under your SELECT 1 level of benefits only.

Non-Emergency Ambulance Services

	SELECT 2	SELECT 3
Ground ambulance*	10%	30%
Air ambulance*	10%	30%

Note

* Prior Certification is required for non-emergency air or ground ambulance services and for ambulance services that do not result in transportation. If prior Certification is not obtained, benefits will be reduced to 50% of the contracted rate through SELECT 2 and 50% of Maximum Allowable Amount through SELECT 3.

Office Visits

	SELECT 2	SELECT 3
Visit to Physician, Physician Assistant or Nurse Practitioner	$20	30%
Specialist consultation	$20	30%
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$35	30%
Vision or hearing examination (for diagnosis or treatment)	Not Covered	Not Covered
Chiropractic Care	Not Covered	Not Covered

Preventive Care Services

	SELECT 2	SELECT 3
Preventive care for children (through age 17)	$0	30%
Preventive care for adults (18 and older)	$0	Not Covered

Notes

Covered services include, but are not limited to, annual preventive physical examinations, immunizations, 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 for details.

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

Hospital Visits by Physician

	SELECT 2	SELECT 3
Physician visit to Hospital or Skilled Nursing Facility	10%	30%

Note

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

Allergy, Immunizations and Injections

	SELECT 2	SELECT 3
Allergy testing	$20	30%
Allergy injection services	10%	30%
Allergy serum	$20	30%
Immunizations for occupational purposes or foreign travel	Not Covered	Not Covered
Injections (except for Infertility)		
Office based injectable medication (per dose)	10%	30%

Notes

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

Rehabilitation Therapy

	SELECT 2	SELECT 3
Physical therapy	$20	30%
Occupational therapy	$20	30%
Speech therapy	$20	30%
Pulmonary rehabilitation therapy	$20	30%
Cardiac rehabilitation therapy	$20	30%

Notes

All rehabilitation therapy services obtained through SELECT 2 and SELECT 3 are limited to a combined maximum of 60 visits each Calendar Year. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations.*

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

Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the contracted rate through SELECT 2 and reduced to 50% of the Maximum Allowable Amount through SELECT 3.

* *The coverage described above in relation to Medically Necessary rehabilitative services for post-mastectomy lymphedema syndrome 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.*

Care for Conditions of Pregnancy

	SELECT 2	SELECT 3
Prenatal or postnatal office visit	10%	30%
Newborn care office visit (birth through 30 days)	$20	30%
Physician visit to the mother or newborn at a Hospital**	10%	30%
Normal delivery, including cesarean section*	10%	30%
Complications of pregnancy	See note below	See note below
Genetic testing of fetus*	10%	30%
Circumcision of newborn (birth through 30 days)***	10%	30%

Notes

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

Please refer to pregnancy under the "Covered Services and Supplies" section.

Applicable Copayment or Coinsurance 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 or Coinsurance will apply.

Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full under SELECT 2. 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” in the “Covered Services and Supplies” section.

* Prior Certification is required. For inpatient services, Certification must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3. In addition, a $250 Deductible will be charged for each uncertified Hospital admission through SELECT 2 and SELECT 3. Please refer to the "Certification Requirement" section for exceptions applicable to Certification of Maternity Hospital length of stay.

Certification is not required for the first 48 hours of inpatient Hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, Health Net should be notified within 24 hours following birth.

Although Health Net does not require Certification for maternity care, please notify Health Net of your pregnancy at the time of the first prenatal visit.

** One Copayment per visit.

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

Family Planning

	SELECT 2	SELECT 3
Sterilization of females		
Child (through age 17)	$0	30%
Adult (age 18 and older)	$0	Not covered
Sterilization of males		
Child (through age 17)	$100	30%
Adult (age 18 and older)	$100	Not covered

Notes

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

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

	SELECT 2	SELECT 3
Infertility services (all services that diagnose, evaluate or treat Infertility)	Not covered	Not covered

Other Professional Services

	SELECT 2	SELECT 3
Surgery*	10%	30%
Assistance at surgery*	10%	30%**
Administration of anesthetics	10%	30%
Chemotherapy	$20	30%
Radiation therapy	$20	30%
Laboratory and diagnostic imaging (including x-ray) services*	10%	30%
Medical social services	10%	30%
Patient education***	Not Covered	Not Covered
Nuclear medicine (use of radioactive materials)	10%	30%
Renal dialysis	$20	30%
Organ, tissue or stem cell transplants*	10%	Not Covered

Notes

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3. Prior Certification for x-ray and laboratory procedures is only required for CT, MRA, MRI, PET and SPECT.

** Non-emergency services provided by an assistant surgeon in an OON facility are pre-authorized and covered only when determined by Health Net to be Medically Necessary.

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

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

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

Medical Supplies

	SELECT 2	SELECT 3
Durable Medical Equipment***	50%	Not Covered
Orthotics (such as bracing, supports and casts)	10%	Not Covered
Diabetic equipment*	50%	Not Covered
Diabetic footwear	10%	Not Covered
Prostheses (internal or external)***	10%	Not Covered
Blood or blood products	10%	30%
Hearing aids	10%	30%

Limitation

The hearing aids Copayment will apply toward the purchase of the hearing aid. Hearing aids are covered to a maximum payment of $1000 every 36 months, maximum combined for SELECT 2 and SELECT 3. Coverage includes repair and maintenance of the hearing aid at no additional charge. The initial hearing exam and fitting are also subject to the hearing examination Copayment. Look under the "Office Visits" heading in this "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section to determine any additional Copayment that may apply. Additional charges for batteries (including the first set) or other equipment related to the hearing aid, or replacement of the hearing aid are not covered.

Notes

Refer to the “Prescription Drug” portion of the “Schedule of Benefits and Copayments – SELECT 1” section for drugs for the treat hemophilia benefits, including blood factors.

Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by a Health Net designated contracted vendor for Durable Medical Equipment. Preferred Providers through SELECT 2 that are not designated by Health Net as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable Medical Equipment is not covered if provided by an Out-of-Network Provider.

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 this “Covered Services and Supplies” section.

* For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Services and Supplies" section.

***Prior Certification may be required. Please refer to the "Certification Requirement" section for details. If prior Certification is required but not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3.

****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

	SELECT 2	SELECT 3
Home health visit*	$20	30%

Notes

SELECT 2 and SELECT 3 Home Health Care Services have a combined Calendar Year maximum limit of 100 visits. The Coinsurance for SELECT 3 is applicable as of the first home health visit.

Copayments are required for home health visits on and after the 31st calendar day of the treatment plan for SELECT 2.

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3.

Hospice Services

	SELECT 2	SELECT 3
Hospice care*	10%	30%

Note

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of Maximum Allowable Amount through SELECT 3. In addition, a $250 Deductible will be charged for each uncertified Hospital admission through SELECT 2 and SELECT 3.

Inpatient Hospital Services

	SELECT 2	SELECT 3
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services*	10%	30%

Notes

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3. In addition, a $250 Deductible may be charged for each uncertified Hospital admission through SELECT 2 and SELECT 3.

The above Copayments apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the “Hospital Visits by Physician,” “Care for Conditions of Pregnancy” and “Other Professional Services” headings to determine any additional Copayments that may apply.

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

The above Copayment is applicable for each day 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 for the newborn patient will apply.

Outpatient Facility Services

	SELECT 2	SELECT 3
Outpatient facility services (other than surgery)*	10%	30%
Outpatient surgery (surgery performed in a Hospital or Outpatient Surgical Center only)*	10%	30%

Notes

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

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

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 or Coinsurance that is required when these services are performed at your Physician’s office.

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

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

Use of a Hospital emergency room appears in the first item at the beginning of the "Schedule of Benefits and Copayments – SELECT 1" section and in the second item of this "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section.

* Outpatient Services may require prior Certification. Please refer to the "Certification Requirement" section for details.

Skilled Nursing Facility Services

	SELECT 2	SELECT 3
Room and board in a semiprivate room with ancillary (additional) services*	10%	30%

Limitation

Skilled Nursing Facility services are covered for up to a combined maximum of 60 days a Calendar Year for each Member under SELECT 2 and SELECT 3.

Notes

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 2 and SELECT 3. In addition, a $250 Deductible may be charged for each uncertified Hospital admission through SELECT 2 and SELECT 3.

Mental Disorders and Chemical Dependency Benefits

Copayments for covered services provided for the treatment of Mental Disorders and Chemical Dependency are the same as the Copayments required for the services when provided for a medical condition.

Mental Disorder and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which contracts with Health Net to administer these benefits.

Severe Mental Illness or Serious Emotional Disturbances of a Child	SELECT 2	SELECT 3
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management, drug therapy monitoring)	$15	30%
Outpatient group therapy session	$7.50	30%
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 therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$0	30%
Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in		

accordance with the rules and criteria established by Health Net)	$15	30%
Participating Mental Health Professional visit to Hospital, behavioral health facility or Residential Treatment Center	$0	30%
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center*	$0	30%
Other Mental Disorders	**SELECT 2**	**SELECT 3**
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15	30%
Outpatient group therapy session	$7.50	30%
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)	$0	30%
Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net)	$15	30%
Participating Mental Health Professional visit to Hospital, behavioral health facility or Residential Treatment Center	$0	30%
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center*	$0	30%

Chemical Dependency	SELECT 2	SELECT 3
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15	30%
Outpatient group therapy session	$7.50	30%
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization)	$0	30%
Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net)	$15	30%
Participating Mental Health Professional visit to Hospital, behavioral health facility or Residential Treatment Center	$0	30%
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center*	$0	30%
Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center*	$0	30%

Notes

* Prior Certification is required. If prior Certification is not obtained, benefits will be reduced to 50% of the Contracted Rate through SELECT 2 and 50% of the Maximum Allowable Amount through SELECT 3. In addition, a $250 Deductible may be charged for each uncertified Hospital admission through SELECT 2 and SELECT 3.

The applicable Copayment for outpatient services (including intensive outpatient care and partial hospitalization/day treatment program) is required for each visit.

Prescription Drugs

Prescription Drugs are covered when prescribed by Preferred or Out-of-Network Providers. Please refer to the "Prescription Drugs" portion of the "Schedule of Benefits and Copayments – SELECT 1" section for the Copayment information. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portions of the "Covered Services and Supplies" and the "Exclusions and Limitations" sections.

OUT-OF-POCKET MAXIMUM-SELECT 2 AND SELECT 3

The SELECT 2 and SELECT 3 Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for SELECT 2 and SELECT 3 covered services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Deductibles, Copayments or Coinsurance you pay for SELECT 2 and SELECT 3 covered services and supplies under this *Evidence of Coverage* in any one Calendar Year equals the "SELECT 2 and SELECT 3 Out-of-Pocket Maximum" amount or "SELECT 3 Out-of-Pocket Maximum" amount listed below, no payment for SELECT 2 or SELECT 3 covered services and benefits may be imposed on any Member, except as described in the "Exceptions to OOPM" below and as stated elsewhere in this EOC.

The SELECT 2 and SELECT 3 OOPM amounts for this Plan are:

	SELECT 2 (PPO)	SELECT 3 (OON)
One Member	$2,000	$3,000
Family (three or more Members)	$6,000	$9,000

Any Deductible, Copayment or Coinsurance paid for covered services received from a SELECT 2 provider will also apply toward the OOPM for SELECT 1 and SELECT 3. Any Deductible or Coinsurance paid for covered services received from a SELECT 3 provider will also apply toward the OOPM for SELECT 1 and SELECT 2. In addition, any Deductible, Copayment or Coinsurance paid for covered services received from a SELECT 1 provider will also apply toward the OOPM for SELECT 2 and SELECT 3.

Exceptions to SELECT 2 and SELECT 3 OOPM

Your payments for services or supplies that SELECT 2 and SELECT 3 do not cover will not be applied to the SELECT 2 and SELECT 3 OOPM amount.

The following Coinsurance, Copayments, Deductible and expenses paid by you for covered services or supplies under this Plan will not be applied to the SELECT 2 and SELECT 3 OOPM amount:

- Services for which Certification was required, but not obtained.

You are required to continue to pay these Coinsurance and Copayments listed in the bullets above after the SELECT 2 and SELECT 3 OOPM has been reached. In addition, you will continue to pay any charges billed by a SELECT 3 provider in excess of the Maximum Allowable Amount.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

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

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

- Spouse: The Subscriber's lawful spouse as defined by California law (The term "spouse" also includes the Subscriber's Domestic Partner as defined in the "Definitions" section).
- Children: The children of the Subscriber or 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.

Please contact your Group administrator to discuss additional eligibility requirements.

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 you receive such notice from Health Net in order to continue coverage for a disabled child past the age limit.

If you are *continuing* coverage for a disabled child, you must provide Health Net with proof of incapacity and dependency within 30 days of the date the child reaches 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 SELECT 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 SELECT 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 SELECT Plan takes effect, if the employee is eligible on that date; or
- When any waiting or probationary period required by the Group has been completed.

Eligible employees who enroll in this SELECT 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 SELECT Plan, you may enroll your new spouse (and your spouse's eligible children) within 30 days of the date of marriage. Coverage begins on the first day of the calendar month following the date application for coverage is received.

Domestic Partner: If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may enroll your new Domestic Partner (and his or her eligible children) within 30 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 30 days of the formation of the domestic partnership according to your Group's eligibility rules.

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

Newborn Child: A child newly born to the Subscriber or 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 30th day.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group under SELECT 1. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

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

The child will be assigned to the Subscriber's Physician Group under SELECT 1.

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

Health Net will require written proof of the right to control the child's health care when you enroll 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 30 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, the SELECT Plan will cover the remainder of that confinement only if you inform Health Net's Customer Contact Center upon your Effective Date about the confinement.

Health Net 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 coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" or "Newly Acquired Dependents" provisions above.)

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 Group should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

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

Exceptions to Late Enrollment Rule

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

1. **You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced**
   If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you
   - If you never received from your Group or signed a form explaining the consequences of your decision, or
   - If 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 SELECT 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 Group stops making contributions toward employee's or dependent's coverage.
- When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual.
- The other Subscriber or employee dies.
- The Subscriber and spouse are divorced or legally separated and this causes loss of the other group coverage.
- Loss of coverage because 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.

1. **You Lose Eligibility from an Access for Infants and Mothers Program (AIM) Plan 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.
2. **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 SELECT Plan.
3. **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. A court ordered dependent may be added without any regard to open enrollment restrictions.

If the exceptions in 2 or 4 above apply, you must enroll within 30 days of the loss of coverage. If you wait longer than 30 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 SELECT Plan

If you are covered by this SELECT Plan as a Subscriber, you can enroll your new dependent if you request enrollment within 30 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 SELECT Plan

If you previously declined enrollment in this SELECT 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 30 days of childbirth, marriage, adoption or placement for adoption.

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

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

If you do not enroll yourself, the new dependent and any other Family Members within 30 days of acquiring the new dependent, you will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for you and all Family Members who enroll within 30 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 or domestic partnership, the Effective Date will be the first of the month following the date application for coverage is received.
- 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 SELECT Plan and you wish to have coverage for a newborn or adopted child who is ill, please contact your Group as soon as possible and ask that you (the employee) and the newborn or adopted child be enrolled. An employee must be enrolled in order for his or her eligible dependent to be enrolled.

While you have 30 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 the "Introduction to Health Net" section, 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 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 our Customer Contact Center at the telephone number on your Health Net ID Card for prompt review of your request.

Effective Date of Transfer

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

If your request for a transfer is not allowed because of 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.

All Group Members

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

Termination for Nonpayment of Subscription Charges

If the Group fails to pay the required subscription charges when due, the Group Service Agreement could be canceled after a 30-day grace period. Concurrent with the group billing and before the subscription charges due date, a Notice of Consequences for Nonpayment of Premiums will be sent. The Notice of Consequences for Nonpayment of Premiums will include the due date, the consequences for not paying the subscription charges by the due date, and information regarding Health Net continuing to provide coverage during a 30-day grace period that begins the first day after the last day of paid coverage.

When subscription charges are not paid by the due date, a Notice of Cancellation for Nonpayment of Premiums and Grace Period is generated. The Notice will be dated and include the reason for the prospective cancellation due to non-payment of premiums, effective date of the cancellation, dollar amount due to Health Net, the last day of paid coverage, the start and last day of the grace period after which coverage will be cancelled if subscription charges are not paid. Coverage will continue during the grace period but the Member is responsible for unpaid premiums and any required copayments, coinsurance or deductible amounts required. The Notice of Cancellation for Nonpayment of Premiums and Grace Period will also include details of the right to request a review of the termination by the Director of the California Department of Managed Health Care and information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal. The 30-day grace period starts the first day following the last day of paid coverage.

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.

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

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

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

- This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:
  1. The date established by the order.
  2. The date the order expired.
- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to the Subscriber only because of the marriage, will end.
- When the Member ceases to reside in the Service Area, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred. However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area, does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care. Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by Health Net (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).
- For any termination for loss of eligibility, a Notice of Cancellation, Rescission or Nonrenewal will be sent and will include: (a) the reason for and effective date of the termination; (b) details of the right to request a review of the termination by the Director of the California Department of Managed Health Care; and (c) information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal.

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 the "General Provisions" section for information about how to appeal Health Net's decision to terminate your coverage.

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

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

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

Coverage Options Following Termination

If coverage through this SELECT 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.

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

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

  Choosing Cal-COBRA: If an eligible Member wishes to choose Cal-COBRA Continuation Coverage, 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.

- **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."

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 and Coinsurance payments shown in the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections will continue to apply.

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

Benefits will not be extended if coverage was terminated for cause as stated in the "Individual Members - Termination for Cause" provision of the "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

In order for a service or supply to be covered, it must be Medically Necessary and authorized according to procedures Health Net has established. Any covered service may require a Copayment, Coinsurance payment or have a benefit limit. Refer to the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments– SELECT 2 and SELECT 3" sections of this Evidence of Coverage for details.

Under SELECT 1 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 prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

With SELECT 2 you may refer to the *Health Net Network Directory* for a Preferred Provider of your choice to provide to you SELECT 2 benefits. When you use the SELECT 3 Tier, you have the freedom to select any Physician and Health Net will reimburse you at the Maximum Allowable Amount for SELECT 3 benefits. Please refer to the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section to determine benefits covered under each Tier.

Under SELECT 2 and SELECT 3, services by certain providers may be covered only when a medical doctor (M.D.) or doctor of osteopathy (D.O.) refers you to them. Please refer to the definition of "Physician" in the "Definition" section of this *Evidence of Coverage* for more details.

When using your SELECT 2 and SELECT 3 benefits make sure prior Certification is not required before receiving services from any provider. Please refer to the "Certification Requirement" section of this *Evidence of Coverage* for details.

The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a covered service.

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

Medical Services and Supplies

Some services and supplies that may be covered under SELECT 1 may not be covered under SELECT 2 and SELECT 3. Please refer to the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections of this Evidence of Coverage to determine the benefits covered under each Tier.

SELECT 1, SELECT 2, and SELECT 3

Office Visits

Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals. To receive SELECT 1 level benefits you will need to be referred by your Primary Care Physician.

Preventive Care Services

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

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

- U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/).
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (http://www.cdc.gov/vaccines/schedules/index.html).
- Guidelines for infants, children, 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 is 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;
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (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) screening and 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. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. 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 the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

Surgical Services

Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered. Non-emergency services provided by an assistant surgeon in an Out of Network (OON) facility are pre-authorized by Health Net and covered only when determined by Health Net to be Medically Necessary. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement. Health Net uses Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with Health Net’s normal claims filing requirements.

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

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

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

Gender Reassignment Surgery

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

qualified provider in conjunction with gender reassignment surgery or a documented gender reassignment surgery treatment plan.

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Home Visit

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

Rehabilitation Therapy

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

Cardiac Rehabilitation Therapy

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

Clinical Trials

Routine patient care costs for items and services furnished in connection with participating in an approved clinical trial are covered when Medically Necessary, authorized by Health Net, and either the Member's treating Physician has recommended participation in the trial or the Member has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by non-participating providers are covered only when the protocol for the trial is not available through a participating provider. 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.

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

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

- The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- A cooperative group or center of any of the entities described above; or
- The FDA as an Investigational new drug application.

“Life threatening condition” means any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted.

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

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

Pulmonary Rehabilitation Therapy

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

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 the "Schedule of Benefits and Copayments - SELECT 1" and the "Schedule of Benefits - SELECT 2 and SELECT 3" sections, under the headings "Care for Conditions of Pregnancy" and "Inpatient Hospital Services" for Copayment and Coinsurance requirements.

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

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

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

Your Physician will not be required to obtain authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled or elective cesarean sections must be authorized under your SELECT 1 Tier and will require prior Certification under your SELECT 2 and SELECT 3 Tiers. Please notify Health Net upon confirmation of pregnancy when you obtain care for conditions of pregnancy under the SELECT 2 or SELECT 3 benefit levels.

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).

Medical Social Services

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

Home Health Care Services

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

Home Health Care Services must be ordered by your Physician, approved by 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 the "Definitions" section. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift

care services) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

Ambulance Services

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

For SELECT 1, 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.

For SELECT 2 and SELECT 3, Ambulance services that do not meet the criteria for Emergency Care may require Certification. Please refer to the "Certification Requirement" section for more information.

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

Hospice Care

Hospice care is available for Members diagnosed as terminally ill by a 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 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, bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are made for the Member.

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

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

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

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

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

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and Orthotics are not subject to such quantity limits.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of the "Exclusions and Limitations" section. Please refer to "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3." for the applicable Copayment or Coinsurance.

Durable Medical Equipment is covered only under SELECT 1 and SELECT 2.

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 and Supplies

Diabetic equipment is covered as shown in the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

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

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

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

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

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunization and Injections" portion of this section).
- Self-management training, education and medical nutrition therapy will be covered under SELECT 1, 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.

Hearing Aids

Standard hearing devices (analog or digital) which typically fit in or behind the outer ear, used to restore adequate hearing to the Member and are determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to the "Schedule of Benefits and Copayments- SELECT 1" and "Schedule of Benefits and Copayments – Select 2 and 3" sections for more information.

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 scheduled surgery that has been authorized as certified, as appropriate.

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.

Reconstructive Surgery

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

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

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

Health Net and the contracting Physician Group determine the feasibility and the 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.

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.*

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 and cardiac rehabilitation therapy, laboratory tests, X-rays, radiation therapy and chemotherapy) are subject to the same Copayment which is required when these services are performed at your Physician's office.

Please refer to the "Schedule of Benefits and Copayments - SELECT 1" and "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" sections for your appropriate Copayment or Coinsurance payment that would apply to your outpatient visit.

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 the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – Select 2 and SELECT 3" sections for more information.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Teladoc Consultation Telehealth Services

Health Net contracts with Teladoc to provide telehealth services for medical, Mental Disorders and Chemical Dependency conditions. Teladoc services are not intended to replace services from your Physician, but are a supplemental service.

Teladoc consultations provide primary care services by telephone or secure online video. Teladoc providers may be used when your Physician's office is closed or you need quick access to a Physician or Participating Mental Health Professional. Teladoc consultations are confidential consultations by secure telephone and online video. You do not need to contact your Primary Care Physician prior to using Teladoc consultation services.

Medical Services –Teladoc medical consultations use a network of U.S. board-certified Physicians who are available 24 hours a day by telephone and from 7:00 a.m. through 9:00 p.m. by secure online video, 7 days a week. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

Mental Disorders and Chemical Dependency Services – Teladoc consultations for Mental Disorders and Chemical Dependency services use a network of Participating Mental Health Professionals who are available by appointment to Members who are 18 years of age or older. The Teladoc Participating Mental Health Professional can provide diagnosis, talk therapy and prescription/medication management, when appropriate.

Teladoc consultation services may be obtained by calling **1-800-TELADOC (800-835-2362)** or visiting www.teladoc.com/hn. Before Teladoc services may be accessed, you must complete a Medical History Disclosure (MHD) form, which can be completed online at Teladoc's website at no charge or printed, completed and mailed or faxed to Teladoc.

Prescription Drug Orders received from a Teladoc Physician or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the "Prescription Drugs" portion of the "Schedule of Benefits and Copayments" section.

These services are subject to the limitations described in the "Telehealth Services" portion of "Exclusions and Limitations," section.

Teladoc consultation services do not cover:

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

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.

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

Benefits are limited to the number of days of care stated in the "Schedule of Benefits and Copayments - SELECT 1" and "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" sections.

Surgically Implanted Drugs

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. Bariatric surgery is covered only under the SELECT 1 and SELECT 2 level of benefits. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your 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 and any other expenses not specifically listed are specifically excluded.

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

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

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment, including refractive eye examinations, are covered as shown in the "Schedule of Benefits and Copayments - SELECT 1" and "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" sections. Preventive vision and hearing screening are covered as Preventive Care Services.

SELECT 1 – Additional Benefits

The following are medical services and supplies that are covered under the SELECT 1 benefit Tier, in addition, to the benefits noted in the "SELECT 1, SELECT 2 and SELECT 3" portion of this subsection.

Hearing Aids

Standard hearing devices (analog or digital), which typically fit in or behind the outer ear, used to restore adequate hearing to the Member and determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to the "Schedule of Benefits and Copayments – Select 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections for more information.

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. Outpatient dialysis received out of the United States is not a covered service.

CVS MinuteClinic Services

CVS MinuteClinic visits for Preventive Care Services and for the diagnosis and evaluation of minor illnesses or injuries are covered as shown in the "Schedule of Benefits and Copayments – SELECT 1" section.

- Preventive Care Services that may be obtained at a CVS MinuteClinic include services such as:
- Vaccinations;
- Health condition monitoring for asthma, diabetes, high blood pressure or high cholesterol; and
- Wellness and preventive services including, but not limited to, asthma, cholesterol, diabetes and blood pressure screenings, pregnancy testing and weight evaluations.

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

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

You do not need prior authorization or a referral from your Primary Care Physician or contracting Physician Group in order to obtain access to CVS MinuteClinic services. However, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations under the SELECT 1 level of benefits.

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits and Copayments - SELECT 1" and the "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" sections. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits and Copayments - SELECT 1" and the "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" sections.

*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 I.D. card.

Self-Referral for Reproductive and Sexual Health Care Services

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits and Copayments – SELECT 1" section. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments – SELECT 1" section.

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. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

Allergy serum is covered.

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

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 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*.

Infertility services (including artificial insemination procedures, office visits, follicle ultrasounds and sperm washing), gamete intrafallopian transfer (GIFT) and supplies are covered as shown under "Infertility Services" in the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections, but there are significant exclusions. Please refer to the "Conception by Medical Procedures" portion of the "Exclusions and Limitations" section for more information.

This Plan also covers Medically Necessary services and supplies for established fertility preservation treatments when treatment for cancer or gender dysphoria 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. This benefit is subject to the applicable Copayments shown in the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of

Benefits and Copayments – SELECT 2 and SELECT 3" sections, as would be required for covered services to treat any illness or condition under this Plan.

Patient Education

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

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. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Medically Necessary services, in connection with an organ, stem cell or tissue 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. 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.

Prostheses

Internal and external prostheses required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, devices to restore speaking after 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 are covered.

Health Net or your 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 contracting 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.

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

SELECT 2 and SELECT 3 - Additional Benefits

The following are medical services and supplies that are covered under your SELECT 2 and SELECT 3 Tiers in addition to the benefits noted in the "SELECT 1, SELECT 2 and SELECT 3" portion of this subsection.

Some services and supplies that may be covered under SELECT 2 may not be covered under SELECT 3. Please refer to the "Schedule of Benefits and Copayments– SELECT 2 and SELECT 3" sections of this *Evidence of Coverage* to determine the benefits covered under each Tier.

Some of these medical services and supplies may require prior Certification in order to avoid a reduction in benefits. Please refer to the "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" section and to the "Certification Requirement" section of this *Evidence of Coverage* for further information.

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 are covered.

Self-injectable drugs (other than insulin) and needles and syringes used with these self-injectable drugs are considered Specialty Drugs, which are subject to Prior Authorization and must be obtained through

Health Net's contracted specialty pharmacy vendor. Your PCP or treating Physician will coordinate the authorization and upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor will charge you for the appropriate Copayment or Coinsurance shown in "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3." Refer to Health Net's Commercial Formulary on our website at www.healthnet.com for the Specialty Drugs listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

Immunizations for foreign travel/occupational purposes are not covered under SELECT 2 and SELECT 3 benefits.

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered and 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 applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), HCPCS Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage. Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing) and Orthotics are not subject to such quantity limits. When applicable, coverage includes fitting and adjustment of covered equipment or devices.

Prostheses

Internal and external prostheses required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, devices to restore speaking after 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 are covered.

The device must be among those that the Food and Drug Administration has approved for general use. If two or more types of medically appropriate devices are available, Health Net will determine which device or appliance will be covered.

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.

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 under SELECT 1 or precertified under SELECT 2 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 or precertification is obtained. Preferred Providers that are

not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Medically Necessary services, in connection with an organ, stem cell or tissue 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. 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.

Charges for reasonable and appropriate computer searches for acceptable organs and tissues are not covered under SELECT 2.

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

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

Prescription Drugs (SELECT 1, SELECT 2 and SELECT 3)

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

Covered Drugs and Supplies

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

Tier 1 Drugs (Primarily Generic) and Tier 2 Drugs (Primarily Brand)

Tier 1 and Tier 2 Drugs listed in the Health Net Drug Commercial Formulary are covered, when dispensed by Participating Pharmacies and prescribed by a Member Physician or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net to be covered. The fact that a drug is listed in the Commercial Formulary does not guarantee that your Physician will prescribe it for you for a particular medical condition.

Tier 3 Drugs

Tier 3 Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Tier 3 on the Commercial Formulary; or

- Not listed in the Health Net Commercial Formulary that are not excluded or limited from coverage.

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

Please refer to the "Commercial Formulary" 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, unless a Brand Name Drug is specifically requested by the Physician or the Member, subject to the Copayment requirements described in the "Prescription Drugs" portion of the "Schedule of Benefits and Copayments – SELECT 1" section.

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration.
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 Commercial Formulary 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 Drug Dex; 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:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- 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 Commercial Formulary. Diabetic supplies are also covered including, but not limited to, reusable pen delivery systems, disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors (including those designed to assist the visually impaired) and test strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section under "Diabetic Equipment" for additional information. Refer to the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections for details about the supply amounts that are covered at the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Commercial Formulary. 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.

Smoking Cessation Coverage

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

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 and when there is no similar commercially available product. 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 the "Covered Services and Supplies" section for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier 3 Drug Copayment and is subject to Prior Authorization by the Plan and Medical Necessity.

Sexual Dysfunction Drugs

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

specified in Health Net's Commercial Formulary. For information about Health Net's Commercial Formulary, please call the Customer Contact Center at the telephone number on your ID card.

Infertility Drugs

Infertility Drugs are covered when prescribed by a Physician through SELECT 1. These drugs are not covered when prescribed by a Physician through SELECT 2 and SELECT 3.

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.

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

Covered contraceptives are FDA-approved contraceptives 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 Commercial Formulary.

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 in the "Definitions" section, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Care as defined.

Appetite Suppressants or Drugs for Body Weight Reduction

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

The Commercial Formulary

What Is the Health Net Commercial Formulary?

Health Net developed the Commercial Formulary 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 Commercial Formulary when choosing drugs for patients who are Health Net Members. When your Physician prescribes medications listed in the Commercial Formulary, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Commercial Formulary identifies whether a Generic version of a Brand Name Drug exists and whether Prior Authorization is required. If the Generic version exists, it will be dispensed instead of the Brand Name version.

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

How Are Drugs Chosen for the Health Net Commercial Formulary?

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

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

This Committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the Commercial Formulary. The Commercial Formulary is updated as new 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 Commercial Formulary. The voting members are not employees of Health Net. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process for Prescription Drugs

Prior Authorization status is included in the Commercial Formulary – The Commercial Formulary 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 Commercial Formulary, your Physician should call Health Net to determine if the drug requires Prior Authorization.

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

Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the 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. See also the “Schedule II Narcotic Drugs” portion of the “Exclusions and Limitations” section.

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

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

Health Net will reimburse you for the cost of the Prescription Drug, less the Copayment shown in the "Schedule of Benefits and Copayments - SELECT 1" section.

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

Nonparticipating Pharmacies and Emergencies

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

If the above situations apply to you:

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

Health Net will reimburse you for the cost of the Prescription Drug, less the Copayment shown in the "Schedule of Benefits and Copayments - SELECT 1" section.

If you present a Prescription order for a Brand Name Drug, pharmacists 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 in California after 30 days of coverage or if the Prescription Drug was not purchased for Emergency or Urgently Needed Care.

Prescription Drugs dispensed by a Nonparticipating Pharmacy outside of California are covered. You will be required to:

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

Health Net will reimburse you for the Prescription Drug Covered Expenses, less any Copayment shown in the "Schedule of Benefits and Copayments - SELECT 1" section. The maximum charge Health Net will allow for a Prescription Order is the Prescription Drug Covered Expense, as defined in the "Definitions" section. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the

amount of Prescription Drug Covered Expense in addition to the appropriate Deductible and Copayment.

Note: The Prescription Drug portion of the "Exclusions and Limitations" section and the requirements of the Commercial Formulary 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, when appropriate.
- The appropriate Copayment.

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

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 the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the mail order may be less than a 90-consecutive-calendar-day supply.

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.

Chiropractic Services and Supplies

Please read the "Chiropractic Services and Supplies" portion of the "Exclusions and Limitations" section of this Evidence of Coverage.

American Specialty Health Plans of California, Inc. must approve all services and supplies.

Chiropractic Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments – SELECT 1."

American Specialty Health Plans (ASH Plans) will arrange covered Chiropractic Services for you. You may access any Contracted Chiropractor without referral from a Physician or your Primary Care Physician.

You may receive covered Chiropractic Services from any Contracted Chiropractor at any time and you are not required to pre-designate the Contracted Chiropractor prior to your first visit from whom you

will receive covered Chiropractic Services. You must receive covered Chiropractic Services from a Contracted Chiropractor, except that:

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

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

- A new patient examination by a Contracted Chiropractor and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic Services including, without limitation, any referral for x-ray services, radiological consultations, or laboratory services.

The following benefits are provided for Chiropractic Services:

Office Visits

- A new patient exam or an established patient exam is performed by a Contracted Chiropractor for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic 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 Chiropractor 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 Chiropractic 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 an adjustment, a re-examination and other services in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Second Opinion

If you would like a second opinion with regard to covered services provided by a Contracted Chiropractor, you will have direct access to any other Contracted Chiropractor. Your visit to a Contracted Chiropractor 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 Chiropractor.

However, a visit to a second Contracted Chiropractor 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 Chiropractor by another Contracted Chiropractor (the first Contracted Chiropractor). The visit to the first Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests

X-rays and laboratory tests are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as Medically Necessary Chiropractic Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH Plans to provide those services. A Copayment is not required.

X-ray second opinions are covered only when performed by a radiologist to verify suspected tumors or fractures.

Chiropractic Appliances

Chiropractic Appliances are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans for up to the maximum benefit shown in the "Schedule of Benefits and Copayments - SELECT 1" section.

Mental Disorders and Chemical Dependency Benefits

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

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

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

Telehealth services for Mental Disorders and Chemical Dependency are provided by Teladoc as described under "Teladoc Consultation Telehealth Services" in the "Medical Services and Supplies" portion of this "Covered Services and Supplies" section.

How to Obtain Care

SELECT 1

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 and neuropsychological testing, outpatient electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS)), outpatient detoxification, partial hospitalization, day treatment, half-day partial hospitalization and 23-hour patient observation;
- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing and intensive outpatient services; and
- Behavioral health treatment for Pervasive Developmental Disorder or Autism (see below under “Outpatient Services”).

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." 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 under the SELECT 1 benefit level 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 the “Definitions” section, services and supplies will not be covered for that condition under SELECT 1. However, the Behavioral Health Administrator may direct you to community resources where alternative forms of assistance are available. See the “General Provisions” section for the procedure to request Independent Medical Review of a Plan denial of coverage. Medically Necessary speech, occupational and physical therapy services are covered under the terms of this plan, regardless of whether community resources are available.

For additional information on accessing mental health services, visit our website at www.healthnet.com 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 go to the nearest Hospital. If your situation is not so severe, or if you are unsure of whether an emergency condition exists, you may call the Behavioral Health Administrator at the Customer Contact Center telephone number shown on your Health Net ID Card. Please refer to the "Emergency and Urgently Needed Care" portion of "Introduction to Health Net" for more information.

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. You may obtain a copy of this policy from the Customer Contact Center. Second opinions will only be authorized for Participating Mental Health Professionals, unless it is demonstrated that an appropriately qualified Participating Mental Health Professional is not available. 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 is order to be covered at the SELECT 1 benefit level.

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 SELECT 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 in order for the services to be covered under the SELECT 1 benefit level.

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.

SELECT 2

SELECT 2 coverage applies when you receive care from a Health Net SELECT 2 Preferred Provider listed in the *Health Net Network Directory*. Health Net contracts with these providers to furnish services at a reduced cost. Health Net will pass that cost savings to you when you use a Health Net Preferred Provider. Simply find the provider you wish to see in the Health Net Preferred Provider Directory and schedule an appointment. To obtain a copy of the directory, please contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com. Behavioral treatment for pervasive developmental disorder and autism beyond the initial six months of treatment and inpatient services require Certification as described below in the "Certification Requirement" section.

Certification is required for non-emergency Mental Disorders and Chemical Dependency services: inpatient admissions, outpatient psychological and neuropsychological testing; behavioral health treatment beyond the initial six months of treatment for pervasive developmental disorder or autism; outpatient Electroconvulsive Therapy (ECT); and outpatient transcranial magnetic stimulation. If a

Member receives Medically Necessary, non-emergent treatment without obtaining Certification first, the noncertification penalty may apply.

Preadmission Certification and continued stay Certification is required for both Chemical Dependency rehabilitation and non-emergency detoxification services. All admissions for rehabilitation are elective and must be Certified as Medically Necessary prior to admission. Detoxification services are covered only when Certified or as Emergency Care. The Certification criteria shall not be considered satisfied unless the patient has been personally evaluated by a Physician or other licensed health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

Payment of benefits for Mental Disorders and Chemical Dependency services will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is required but not obtained prior to services being rendered.

Emergency care services, regardless of whether the Covered Person is admitted, do not require Certification.

SELECT 3

You may also receive medical care from any licensed Out-of-Network Provider or Physician Group. Your option to obtain the benefits in this *Evidence of Coverage* is referred to as SELECT 3. In this case, however, you lose the protection of contracted rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Simply schedule an appointment with the provider you desire and the services will be reimbursed to you based on the Maximum Allowable Amount and your benefits, once you submit the claims to Health Net. Behavioral treatment for pervasive developmental disorder and autism beyond the initial six months of treatment and inpatient services require Certification as described below in the "Certification Requirement" section.

Certification is required for non-emergency Mental Disorders and Chemical Dependency services: inpatient admissions, outpatient psychological and neuropsychological testing; behavioral health treatment beyond the initial six months of treatment for pervasive developmental disorder or autism; outpatient Electroconvulsive Therapy (ECT); and outpatient transcranial magnetic stimulation. If a Member receives Medically Necessary, non-emergent treatment without obtaining Certification first, the noncertification penalty may apply.

Preadmission Certification and continued stay Certification is required for both Chemical Dependency rehabilitation and non-emergency detoxification services. All admissions for rehabilitation are elective and must be Certified as Medically Necessary prior to admission. Detoxification services are covered only when Certified or as Emergency Care. The Certification criteria shall not be considered satisfied unless the patient has been personally evaluated by a Physician or other licensed health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

Payment of benefits for Mental Disorders and Chemical Dependency services will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is required but not obtained prior to services being rendered.

Emergency care services, regardless of whether the Covered Person is admitted, do not require Certification.

Covered Services and Supplies

Outpatient Services

Outpatient services are covered as shown in "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections 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: Including 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, are covered as shown in the "Schedule of Benefits and Copayments – SELECT 1" and Schedule of Benefits and Copayments – SELECT 2 and SELECT 3 sections, under "Mental Disorders and Chemical Dependency Benefits."
    - The treatment must be prescribed by a licensed Physician or a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, 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.

Inpatient Services

Inpatient treatment is covered as shown in the "Schedule of Benefits and Copayments - SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections 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 services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations" section.

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

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered.

Serious Emotional Disturbances (SED) of a Child

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits and Copayments - SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

Serious Emotional Disturbances of a Child exist 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: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one years; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental

disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

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.
- Bulimia nervosa.

Other Mental Disorders

Other Mental Disorders are all other Mental Disorders not listed under Severe Mental Illness, Serious Emotional Disturbances of a Child or Chemical Dependency conditions and are covered as shown in the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections under "Mental Disorders and Chemical Dependency Benefits." See also "Mental Disorders" in the "Definitions" section.

CERTIFICATION REQUIREMENT

Some of the Covered Expenses under the SELECT 2 and SELECT 3 Tiers are subject to a requirement of Certification, or treatment review, in order for full benefits to be available to you. Certifications are performed by Health Net. Services provided under your SELECT 1 benefits must be performed or authorized by your Physician Group, except as specifically stated.

Services provided as the result of an emergency are covered at the SELECT 1 benefit level and will not require Certification.

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

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

Services Requiring Certification

Services requiring Certification include but are not limited to:

Inpatient admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Behavioral health facility, except in an emergency
- Hospice
- Hospital, except in an emergency
- Skilled nursing facility
- Substance abuse facility, except in an emergency

Outpatient procedures, services or equipment

- Abdominal paracentesis (when performed at a Hospital*)
- Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
- Acupuncture
- Ambulance: non-emergency, air or ground Ambulance services
- Balloon sinuplasty
- Bariatric procedures
- Capsule endoscopy
- Clinical trials
- Cochlear implants

- Custom Orthotics
- Diagnostic procedures including:
    1. Advanced imaging
        - CT (Computerized Tomography)
        - CTA (Computed Tomography Angiography)
        - MRA (Magnetic Resonance Angiography)
        - MRI (Magnetic Resonance Imaging)
        - PET (Positron Emission Tomography)
    2. Cardiac imaging
        - Coronary computed tomography angiography (CCTA)
        - Myocardial perfusion imaging (MPI)
        - Multigated acquisition (MUGA) scan
        - Echocardiography
    3. Sleep studies
- Durable Medical Equipment (DME)
- Enhanced External Counterpulsation (EEC)
- Experimental or Investigational services and new technologies
- Gender reassignment services
- Genetic testing
- Injection, including epidural, nerve, nerve root, face joint, trigger point, and sacroiliac (SI) joint injections
- Mental Disorders and Chemical Dependency services other than office visits including:
    1. Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
    2. Outpatient Detoxification
    3. Psychological testing
    4. Neuropsychological testing
    5. Outpatient Electroconvulsive Therapy (ECT)
    6. Outpatient Transcranial Magnetic Stimulation (TMS)
    7. Partial Hospital Program or Day Hospital (PHP)
    8. Half-Day Partial Hospitalization
    9. Intensive Outpatient Program (IOP)
- Neuro or spinal cord stimulator

- Occupational and speech therapy (includes home setting)
- Orthognathic procedures (includes TMJ treatment)
- Outpatient pharmaceuticals
  1. Self-injectables
  2. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, free-standing infusion center, home infusion, outpatient surgery center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net website, www.healthnet.com, for a list of Physician-administered drugs that require Certification
- Physical therapy (including home setting)
- Prosthesis
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  1. Bone alteration or reshaping such as osteopathy
  2. Breast reductions and augmentations (includes gynecomastia and macromastia)
  3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
  4. Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
  5. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
  6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
  7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
  8. Hair electrolysis, transplantation or laser removal
  9. Lift such as arm, body, face, neck, thigh
  10. Liposuction
  11. Nasal surgery such as rhinoplasty or septoplasty
  12. Otoplasty
  13. Penile implant
  14. Treatment of varicose veins
  15. Vermilionectomy with mucosal advancement
- Spinal surgery including but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
- Total joint replacements

- Transplant related services
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vestibuloplasty

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

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

Additional services not indicated in the above list may require Certification. Please consult the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections to see additional services that may require Certification.

Exceptions

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

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

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

Certification Procedure

Certification must be requested by you within the following periods:

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

In order to obtain Certification, you or your Physician is responsible for contacting Health Net as shown on your Health Net Identification Card before receiving any service requiring Certification. If you receive any such service and do not follow the procedures set forth in the Certification section, your benefits may be reduced by a percentage stated in the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections and an additional Deductible may apply. However, for services that require notification only, the reduction in benefits and additional Deductible will not apply.

Verbal Certification may be given by Health Net. Written Certification will be sent to you and the provider of service.

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

Effect on Benefits

If Certification is obtained and services are rendered within the scope of the Certification, benefits for Covered Expenses will be provided in accordance with the SELECT 2 and SELECT 3 "Covered Services and Supplies" section.

If Certification is not obtained, or services, supplies or expenses are received or incurred beyond the scope of Certification given, the payable percentage will be the reduced percentage as shown in the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section. Also, an additional Deductible will be applied to Covered Expenses as shown in the "Schedule of Benefits and Copayments - SELECT 2 and SELECT 3" section.

Resolution of Disputes

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

- Either you or your Physician may contact Health Net to request an appeal of Our decision. Refer to the “Grievance and Appeals Process” provision in the “General Provisions” section for more details. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If you remain dissatisfied with the reconsideration decision, please refer to the "Grievance, Appeals, Independent Medical Review and Arbitration" portion of the "General Provisions" section for more information.

EXCLUSIONS AND LIMITATIONS

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

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the *Evidence of Coverage*, exceed *Evidence of Coverage* limitations or are Follow-Up Care (or related to Follow-Up Care) to *Evidence of Coverage* exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to 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 the "Definitions" section. Notwithstanding any exclusions or limitations described in this *Evidence of Coverage*, all Medically Necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.

The following exclusions and limitations apply to your SELECT 1, SELECT 2 and SELECT 3 Tiers.

Services and Supplies

SELECT 1

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

Ambulance Services

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

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

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Care were not met, unless authorized by your Physician Group for SELECT 1 or Certification was obtained for SELECT 2 and SELECT 3, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies;" or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

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 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 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 the "General Provisions" section for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Chiropractic and Acupuncture Services

This Plan does not cover chiropractic or acupuncture services, except as provided by ASH Plans as shown in the “Schedule of Benefits and Copayments – SELECT 1” section and/or as shown in the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section.

Clinical Trials

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

- 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.

Conception by Medical Procedures

Artificial insemination and gamete intrafallopian transfer (GIFT) are covered when a Member and/or the Member’s partner is infertile (refer to Infertility in the "Definitions" section) but the services will only be covered for the Member. The collection, storage or purchase of sperm is not covered.

Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), 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.
- Injections for Infertility when not provided in connection with services that are covered by this Plan or after the Calendar Year maximum of three treatment courses has been met.

Cosmetic Services and Supplies

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

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

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

Then, the following are covered:

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

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

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

Health Net 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****.*

Custodial or Domiciliary Care

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

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

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 Physician Group (under SELECT 1).

CVS MinuteClinic Services

Services required for the treatment of Emergency Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit. Please refer to the "Schedule of Benefits and Copayments – SELECT 1" section 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 MinuteClinics are not intended to replace your Primary Care Physician or Specialist Physician as your primary source of regular monitoring of chronic conditions, but MinuteClinics can, for example, provide a blood sugar test for diabetics, if needed.

Dental Services

Unless otherwise covered as Preventive Care Services, dental services or supplies are limited to the following situations:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of the "Introduction to Health Net" section for more information.
- 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 eight years of age, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.

- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

The following services are not covered under any circumstances, except as 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).

Disorders of the Jaw

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

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

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

Disposable Supplies for Home Use

The SELECT Plan does not cover disposable supplies for home use.

Durable Medical Equipment

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

- 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 the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the “Prostheses” provision of the “Covered Services and Supplies” section and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of "Covered Services and Supplies.”
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this Plan.

Experimental or Investigational Services

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

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

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

Fertility Preservation

Fertility preservation treatments are covered as shown in the “Family Planning” provision in the “Covered Services and Supplies” section. 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.

- 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.

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 the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section.

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

Methadone Maintenance

Methadone maintenance for the purpose of long term opiate craving reduction is not covered.

No-Charge Items

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

Noncovered Treatments

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

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

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

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.

Noneligible Institutions

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

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

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

Any other Nonprescription drug, medical equipment or supply that can be purchased without a Prescription Drug Order is not covered, even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless listed in the Commercial Formulary. 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.

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.”

Personal or Comfort Items

The SELECT Plan does not cover personal or comfort items.

Physician Self-Treatment

The SELECT 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 tests and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Prescribed Drugs and Medications

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

Private Duty Nursing

The SELECT 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

The SELECT 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 Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of 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. Coverage is subject to any required authorization from the Plan or the Member's Physician Group (under SELECT 1). The services must be based on a treatment plan authorized, as required by the Plan or the Member's Physician Group (under SELECT 1). Such services are not covered when medical documentation does not support the Medical Necessity because of the Member’s inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See the "General Provisions" section for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Rehabilitation 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 therapy are met.

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.

Reversal of Surgical Sterilization

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

Residential Treatment Center

Admission to a Residential Treatment Center that is not Medically Necessary is excluded. Admissions that are not considered Medically Necessary and are not covered include, but are not limited to, admissions for Custodial Care, for a situational or environmental change only; or as an alternative to placement in a foster home or halfway house.

Routine Physical Examinations

The SELECT Plan does not cover routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.

Services for Educational or Training Purposes

Except for services related to behavioral health treatment for pervasive development disorder or autism are covered as shown in the "Covered Services and Supplies" section, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California. Examples of excluded services include education and training for 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 not related to the diagnosis or treatment of a covered condition, illness or injury. 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).

Sports Activities

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

State Hospital Treatment

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

Surrogate Pregnancy

The SELECT 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*.

Telehealth Consultations

Consultations provided by telephone are not covered, except as described under "Teladoc Consultation Telehealth Services" in the "Covered Services and Supplies" section.

Telehealth Services

Teladoc consultation services do not cover:

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

Treatment by Immediate Family Members

The SELECT Plan does not cover routine or ongoing treatment, consultation or provider referrals (including, but not limited to, prescribed services, supplies and drugs) provided by the Member's parent, spouse, Domestic Partner, child, stepchild, or sibling. Members who receive routine or ongoing care from a member of their immediate family will be reassigned to another Physician (medical) or a Mental Health Professional (Mental 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. Certain services may be covered as Preventive Care Services; refer to the "Preventive Care Services" provision in the "Covered Services and Supplies" section.

Treatment Related to Judicial or Administrative Proceedings

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

Unauthorized Services and Supplies

The SELECT Plan only covers services or supplies that are authorized by Health Net or the contracting 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 under SELECT 1 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.

Unlisted Services

The SELECT Plan only covers services or supplies that are specified as covered services or supplies in this *Evidence of Coverage*, unless state or federal law requires coverage.

Vision Therapy, Eyeglasses and Contact Lenses

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

SELECT 2

Immunizations or Inoculations

Immunizations or inoculations for adults or children are limited to those provided as Preventive Care Service.

Vision and Hearing Examinations

Eye and ear examinations to determine the need for correction of vision and hearing are not covered.

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 not covered.

SELECT 3

The exclusions and limitations from the "SELECT 1" and "SELECT 2" subsections of the "Services and Supplies" portion of this section also apply to SELECT 3. In addition, the following services and supplies are not covered through your SELECT 3 level of benefits.

Durable Medical Equipment

Any expenses related to equipment which can withstand repeated use, is primary and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Diabetic Equipment and Supplies

Diabetic equipment is not covered under SELECT 3.

Organ, Tissue and Stem Cell Transplants

Any expenses related to the replacement of any body organ, tissue or stem cell, whether non-Experimental or not, are not covered.

Immunizations and Injections

Immunizations and injections, professional services to inject the medications and the medications that are injected are not covered.

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 not covered.

Prostheses

Any expenses that specifically replace missing body parts including, but not limited to, artificial limbs, mammary prostheses, artificial eyes, intraocular lens implants or contact lenses after cataract surgery and colostomy supplies are not covered except as specifically stated.

Sterilizations

Any expenses for sterilization or reversal of sterilization for males is not covered.

Prescription Drugs

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

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

Additional exclusions and limitations:

Allergy Serum

Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See the "Allergy, Immunizations and Injections" portion of the "Schedule of Benefits and Copayments – SELECT 1" and "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections and the "Immunizations and Injections" portion of "Covered Services and Supplies" section for more information.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs prescribed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. In such cases the drug will be subject to Prior Authorization from Health Net.

Devices

Coverage is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and those devices listed under the "Diabetic Drugs and Supplies" provision of the "Prescription Drugs" portion of "Covered Services and Supplies." No other devices are covered even if prescribed by a Member Physician.

Diagnostic Drugs

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

Dietary or Nutritional Supplements

Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a prescription drug product, are limited to drugs that are listed in the Commercial Formulary. Phenylketonuria (PKU) treatment is covered under the medical benefit (see the "Phenylketonuria" portion of the "Covered Services and Supplies" section).

Drugs Prescribed for the Common Cold

Drugs 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, sexual performance, 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 for as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer’s dementia.

Food and Drug Administration (FDA)

Supply amounts for prescriptions that exceed the FDA’s or Health Net’s indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except as described under the “Clinical Trials” provision in the “Medical Services and Supplies” portion of the “Covered Services and Supplies” section and the “Experimental or Investigational Services” provision of this “Exclusions and Limitations” section.

Hypodermic Syringes and Needles

Hypodermic syringes and needles are limited to disposable insulin needles and syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net’s specialty pharmacy vendor under the

Medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies" section). All other syringes, devices and needles are not covered.

Self-Injectable Drugs

Self-injectable drugs obtained through a prescription from a Physician are limited to insulin and sexual dysfunction drugs listed on the Commercial Formulary. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies," section). Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of the "Covered Services and Supplies," section).

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs

Once You have taken possession of drugs, replacement of lost, stolen or damaged drugs is not covered. You will have to pay the retail price for replacing them.

Nonapproved Uses

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

Noncovered Services

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

Nonparticipating Pharmacies in California Only

Drugs dispensed by Nonparticipating Pharmacies in California are not covered, except as specified in the "Use of Nonparticipating Pharmacies" provision of the "Covered Services and Supplies" section.

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

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

Any other Nonprescription Drug 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 Commercial Formulary.

However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment based on recommendations for use by the FDA or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

Schedule II Narcotic Drugs

Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Member Physician. Partial prescription fills are subject to a prorated Copayment based on the amount of the prescription that is filled by the pharmacy. Schedule II narcotic drugs are not covered through mail order.

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 available in that form.

Chiropractic Services

The exclusions and limitations in the "Services and Supplies" portion of this section, also apply to Chiropractic Services.

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

Services, laboratory tests and x-rays and other treatment not approved by ASH Plans and documented as Medically 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:

Anesthesia

Charges for anesthesia are not covered.

Diagnostic Radiology

Coverage is limited to X-rays. No other diagnostic radiology (including 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 Chiropractic Services

Chiropractic care that is (a) investigatory; or (b) an unproven Chiropractic Service that does not meet generally accepted and professionally recognized standards of practice in the chiropractic 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.

Hypnotherapy

Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.

Medically/Clinically Unnecessary Services

Only Chiropractic Services that are necessary, appropriate, safe, effective and that are rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Non-Contracted Providers

Services or treatment rendered by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a referral by ASH Plans.

Nonchiropractic Examinations

Examinations or treatments for conditions unrelated to Neuromusculoskeletal Disorders are not covered. This means that physical therapy not associated with spinal, muscle and joint manipulation, is not covered.

Out-of-State Services

Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.

Services Not Within License

Services that are not within the scope of license of a licensed chiropractor in California.

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.

Vitamins

Vitamins, minerals, nutritional supplements or other similar products, including when in combination with a prescription product, are not covered.

GENERAL PROVISIONS

When the Plan Ends

The Group Service Agreement specifies how long this SELECT Plan remains in effect.

If you are totally disabled on the date that the Group Service Agreement is terminated, benefits will continue according to the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section.

When the Plan Changes

Subject to notification and according to the terms of the Group Service Agreement, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions and eligibility provisions.

Health Net has the right to modify this SELECT Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under "When Coverage Ends" in the "Eligibility, Enrollment and Termination" section regarding termination for 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 SELECT Plan had not been modified, until you are discharged from the Hospital.

Form or Content of the SELECT Plan: No agent or employee of Health Net is authorized to change the form or content of this SELECT Plan. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.

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 complaint if your language needs are not met;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility 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, as applicable to this group health plan, means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net plan;
- 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 **1-800-522-0088** or by submitting a Member grievance form through the Health Net website at www.healthnet.com.

You may also file your complaint in writing by sending information to:

Health Net
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the 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 chiropractic program, call Health Net the 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 he 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, 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 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. Your provider has recommended a Health Care Service as Medically Necessary; or you have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of the provider recommendation, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the Health Care Service is not Medically Necessary; and
3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For 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 Health Net's 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 **1-800-522-0088** 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 the total 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: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that the state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Members who are enrolled in a 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 and 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 SELECT Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident; or
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, Health Net's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this plan, you also grant Health Net an assignment of your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such medical payments carriers to directly reimburse the Plan on your behalf.

Steps You Must Take

If you are injured because of a responsible party, you must cooperate with Health Net's and the medical provider's effort to obtain reimbursement, including:

- Telling Health Net and the medical providers, the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved in your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and
- Hold any money that you or your lawyer receives from the responsible parties or from any source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

How the Amount of Your Reimbursement is Determined

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, Hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid, as summarized below, and will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by law.

- The amount of the reimbursement that you owe Health Net or the medical provider will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the medical provider will also be reduced a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the medical provider for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

* *Reimbursement related to Workers' Compensation benefits, ERISA plans, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Evidence of Coverage and applicable law.*

Surrogacy Arrangements

A Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to Health Net

If you enter into a surrogacy arrangement, you must pay us for covered services and supplies you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments you and/or any of your family members are entitled to receive under the surrogacy arrangement. You also agree to pay us for the covered services and supplies that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if you provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to Health Net in advance of delivery, you will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Duty to Cooperate

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

Surrogacy Third Party Liability –Product Support
The Rawlings Company
One Eden Parkway
LaGrange, KY 40031-8100

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to your surrogacy arrangement and to satisfy Health Net's rights.

You must do nothing to prejudice the health plan's recovery rights.

You must also provide us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Relationship of Parties

Contracting Physician Groups, 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, 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 SELECT 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 SELECT Plan.

Provider/Patient Relationship

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 SELECT 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 SELECT Plan covers.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a Physician Group, Preferred Provider 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 five 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 the "Definitions" section.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider’s contract termination. You must request continued care within 30 days of the provider’s date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider’s date of termination and the request is made as soon as reasonably possible.

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 SELECT 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 SELECT Plan and to determine when services are covered by the SELECT 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 the "Government Coverage" portion of this "General Provisions" section.)

   2. "Plan" does not include nongroup coverage of any type, amounts of Hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other 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; or
         - The parents are not separated (whether or not they ever have been married); or
         - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

         If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

      b. **Court Ordered Responsible Parent**--If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the Plan is given notice of the court decree.

      c. **Parents Not Married, Divorced or Separated**--If the parents are not married or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

         - The Plan of the Custodial Parent.

- The Plan of the spouse of the Custodial Parent.
- The Plan of the non-custodial parent.
- The Plan of the spouse of the non-custodial parent.

3. **Active vs. Inactive Employee**--The plan that covers a person as an employee who is neither laid off nor retired (or 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:
      - A change in the amount or scope of a Plan's benefits.
      - A change in the entity that pays, provides or administers the Plan's benefits.
      - A change from one type of Plan to another (such as from a single Group Plan to that of a multiple Group Plan).

   c. **Measurement of Time Covered**--The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

6. **Equal Sharing**--If none of the preceding rules determines the primary Plan, the allowable expenses shall be shared equally between the Plans.

Effect on the Benefits of this SELECT Plan

A. **Secondary Plan Reduces Benefits**--When this SELECT 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 SELECT 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 SELECT 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 SELECT 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 SELECT 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.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Government Coverage

Medicare Coordination of Benefits (COB)

When you reach age 65, you may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Member enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If you are enrolled in Medicare Part A and Part B and are not an active employee or your employer group has less than twenty employees, then this Plan will coordinate with Medicare and be the secondary plan. This Plan also coordinates with Medicare if you are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If you are not enrolled in Medicare Part A and Part B, Health Net will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the Covered Services described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Physician and authorized by Health Net as required under this *Evidence of Coverage*.

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare Coordination of benefits, unless you are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or
- Write to:

  Medicare Publications
  Department of Health and Human Services
  Centers for Medicare and Medicaid Services
  6325 Security Blvd.
  Baltimore, MD 21207

Medi-Cal

Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration

Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers’ Compensation

This SELECT Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers’ Compensation laws.

If you require covered services or supplies and the injury or illness is work-related and benefits are available as a requirement of any Workers’ Compensation or Occupational Disease Law, Health Net will cover the services then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits

The SELECT 1 benefits of this *Evidence of Coverage* generally provide all covered services and supplies through a network of contracting Physician Groups. Under SELECT 1 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 under 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 SELECT Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim

In most instances, you will not need to file a claim to receive benefits from your SELECT 1 and SELECT 2 Tiers. However, if you utilize SELECT 3 benefits you will need to file a claim and you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit and that you have filed as soon as was reasonably possible.

Call the Health Net Customer Contact Center at the telephone number shown on your Health Net ID Card to obtain claim forms.

If you need to file a claim for services covered under the medical benefit (or the Mental Disorders and Chemical Dependency benefits under SELECT 2 and SELECT 3), please send a completed claim form to:

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

If you need to file a claim for outpatient Prescription Drugs, please send a completed Prescription Drug claim form to:

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

Please call Health Net's Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com to obtain a Prescription Drug claim form.

If you need to file a claim for Emergency Chiropractic Services or for other covered Chiropractic 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 Chiropractic 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 or 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 is 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.

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.

Payment of Claim

Within 30 days of receipt of a claim (refer to "Notice of Claim" above), Health Net shall pay the benefits available under this *Evidence of Coverage* or provide written notice regarding additional information needed to determine our responsibility for the claim.

Payment to Providers or Subscriber Under SELECT 2 and SELECT 3

Benefit payment for Covered Expenses will be made directly to:

- Hospitals which have provider service agreements with Health Net to provide services to you (Contracting Hospitals);
- Providers of ambulance transportation, even if written assignment has not been made by you. However, if the submitted provider’s statement or bill indicates the charges have been paid in full, payment will be made to the Subscriber; or
- Other providers of service not mentioned above, Hospital and professional, when you assign benefits to them in writing.
- Benefit payment for Covered Expenses will be made jointly to other providers and the Subscriber when:
- A written assignment stipulates joint payment; or
- The benefit payment is $2,000 or greater and the submitted bill indicates that there is a balance due.

Exceptions

Joint payment will not be made to contracting Hospitals and providers of ambulance services. Payment to them will be direct as described above.

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

Payment When Subscriber is Unable to Accept

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

Physical Examination

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

Foreign Travel or Work Assignment

Under SELECT 3, medical benefits will be provided for Covered Expenses incurred in a foreign country, as long as the Member has been outside the USA for less than six months in relation to a particular foreign trip or the Subscriber is on temporary work assignment outside the USA and is being

paid in US dollars by the Group and the services or supplies would have been covered had they been incurred in the USA. Determination of a Covered Expense will be based on the amount that is no greater than the Maximum Allowable Amount paid in the USA for the same or a comparable service.

Interpretation of *Evidence of Coverage*

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

Disruption of Care

Circumstances beyond Health Net's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant contracting Physician Group personnel or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgently Needed Care" section under "Introduction to Health Net- SELECT 1."

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.

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.

Covered Entities Duties:

Health Net (referred to as "we" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

This Notice describes how We may use and disclose Your PHI. It also describes your rights to access, amend and manage Your PHI and how to exercise those rights. All other uses and disclosures of Your PHI not described in this Notice will be made only with Your written authorization.

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Your PHI We already have as well as any of Your PHI We receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

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

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

*__This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities:__ Health Net of California, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, LLC, and Health Net Community Solutions Inc.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how We may use or disclose Your PHI without Your permission or authorization:

- ***Treatment*** - We may use or disclose Your PHI to a physician or other health care provider providing treatment to You, to coordinate Your treatment among providers, or to assist us in making prior authorization decisions related to Your benefits.
- ***Payment*** - We may use and disclose Your PHI to make benefit payments for the services provided to You. We may disclose Your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - Processing claims
  - Determining eligibility or coverage for claims
  - Issuing premium billings
  - Reviewing services for medical necessity
  - Performing utilization review of claims
- ***Health Care Operations*** - We may use and disclose Your PHI to perform Our health care operations. These activities may include:
  - Providing customer services
  - Responding to complaints and appeals
  - Providing case management and care coordination
  - Conducting medical review of claims and other quality assessment
  - Improvement activities

  In Our health care operations, We may disclose PHI to business associates. We will have written agreements to protect the privacy of Your PHI with these associates. We may disclose Your PHI to another entity that is subject to the federal Privacy Rules. The entity must have a relationship with You for its health care operations. This includes the following:
  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of health care professionals
  - Case management and care coordination
  - Detecting or preventing health care fraud and abuse.
- ***Group Health Plan/Plan Sponsor Disclosures*** - We may disclose Your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to You, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

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Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** - We may use or disclose Your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If We do contact You for fundraising activities, We will give You the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** - We may use or disclosure Your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If We do use or disclose Your PHI for underwriting purposes, We are prohibited from using or disclosing Your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose Your PHI to remind You of an appointment for treatment and medical care with us or to provide You with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of Your PHI, We may use or disclose Your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, We will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose Your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure Your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose Your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if We have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose Your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court
  - Administrative tribunal
  - Subpoena
  - Summons
  - Warrant
  - Discovery request
  - Similar legal request
- ***Law Enforcement*** - We may disclose Your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order
  - Court-ordered warrant

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- Subpoena
- Summons issued by a judicial officer
- Grand jury subpoena

We may also disclose Your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose Your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose Your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose Your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - Cadaveric organs
  - Eyes
  - Tissues
- ***Threats to Health and Safety*** - We may use or disclose Your PHI if We believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If You are a member of U.S. Armed Forces, We may disclose Your PHI as required by military command authorities. We may also disclose your PHI:
  - To authorized federal officials for national security and intelligence activities
  - The Department of State for medical suitability determinations
  - For protective services of the President or other authorized persons
- ***Workers' Compensation*** - We may disclose Your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose Your PHI in an emergency situation, or if You are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by You. We will use professional judgment and experience to determine if the disclosure is in Your best interests. If the disclosure is in Your best interest, We will only disclose the PHI that is directly relevant to the person's involvement in Your care.
- ***Inmates*** - If You are an inmate of a correctional institution or under the custody of a law enforcement official, We may release Your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide You with health care; to protect Your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, We may disclose Your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of Your PHI.

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Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain Your written authorization to use or disclose Your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request Your written authorization before We make any disclosure that is deemed a sale of Your PHI, meaning that We are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request Your written authorization to use or disclose Your PHI for marketing purposes with limited exceptions, such as when We have face-to-face marketing communications with You or when We provide promotional gifts of nominal value.

Psychotherapy Notes – We will request Your written authorization to use or disclose any of Your psychotherapy notes that We may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individuals Rights

The following are Your rights concerning Your PHI. If You would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke Your authorization at any, the revocation of Your authorization must be in writing. The revocation will be effective immediately, except to the extent that We have already taken actions in reliance of the authorization and before We received Your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of Your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in Your care or payment of Your care, such as family members or close friends. Your request should state the restrictions You are requesting and state to whom the restriction applies. We are not required to agree to this request. If We agree, We will comply with Your restriction request unless the information is needed to provide You with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when You have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that We communicate with You about Your PHI by alternative means or to alternative locations. This right only applies if the information could endanger You if it is not communicated by the alternative means or to the alternative location You want. You do not have to explain the reason is for Your request, but You must state that the information could endanger You if the communication means or location is not changed. We must accommodate Your request if it is reasonable and specifies the alternative means or location where You PHI should be delivered.
- ***Right to Access and Receive Copy of Your PHI*** - You have the right with limited exceptions, to look at or get copies of Your PHI contained in a designated record set. You may request that We provide copies in a format other than photocopies. We will use the format You request unless We cannot practicably do so. You must make a request in writing to obtain access, to Your PHI. If We deny Your request, We will provide You a written explanation and will tell You if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

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- ***Right to Amend Your PHI*** - You have the right to request that We amend, or change, Your PHI if You believe it contains incorrect information. Your request must be in writing and it must explain why the information should be amended. We may deny Your request for certain reasons, for example, if We did not create the information You want amended and the creator of the PHI is able to perform the amendment. If We deny Your request, We will provide You a written explanation. You may respond with a statement that You disagree with Our decision and We will attach Your statement to the PHI You request that We amend. If We accept Your request to amend the information, We will make reasonable efforts to inform others, including people You name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which We or Our business associates disclosed Your PHI. This does not apply to disclosure for purposes of treatment, payment health care operations or disclosures You authorized and certain other activities. If You request this accounting more than once in a 12-month period, We may charge You a reasonable, cost-based fee for responding to these additional request. We will provide You with more information on Our fees at the time of Your request
- ***Right to File a Complaint*** - If You feel Your privacy rights have been violated or that We have violated Our own privacy practices, You can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989), or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- ***Right to Receive a Copy of this Notice*** - You may request a copy of Our Notice at any time by using the contact information list at the end of the Notice. If You receive this Notice on Our web site or by electronic mail (e-mail), You are also entitled to request a paper copy of the Notice.

Contact Information

If You have any questions about this Notice, Our privacy practices related to Your PHI or how to exercise Your rights You can contact us in writing or by phone using the contact information listed below:

Health Net Privacy Office	**Telephone:**	**1-800-522-0088**
Attn: Privacy Official	Fax:	1-818-676-8314
P.O. Box 9103	Email:	Privacy@healthnet.com
Van Nuys, CA 91409		

***This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities:** Health Net of California, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, LLC, and Health Net Community Solutions Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of Your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about You from the following sources:

- Information We receive from You on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about Your transactions with us, Our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about Our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of Our general business practices, We may, as permitted by law, disclose any of the personal financial information that We collect about You, without Your authorization, to the following types of institutions:

- To Our corporate affiliates, such as other insurers;
- To nonaffiliated companies for Our everyday business purposes, such as to process Your transactions, maintain Your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on Our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect Your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access Your personal financial information.

Questions about this Notice:

If You have any questions about this notice:

Please **call the toll-free phone number on the back of Your ID card** or contact Health Net at 1-800-522-0088.

***This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities:** Health Net of California, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, LLC, and Health Net Community Solutions Inc.

DEFINITIONS

This section defines words that will help you understand your SELECT Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

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 Chiropractic Services through a network of Contracted Chiropractors.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

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.

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.

Certification refers to the requirement that certain Covered Expenses require review and approval, frequently prior to the expenses being incurred as specified in the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" section.

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 state licensed to provide Chemical Dependency detoxification services or rehabilitation services.

Chiropractic Appliances are support type devices prescribed by a Contracted Chiropractor specifically for the treatment of a Neuromusculoskeletal Disorder. The devices this SELECT Plan covers are limited to elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar supports, lumbar cushions Orthotics, wrist supports, rib belts home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic Services are chiropractic manipulation services provided by a Contracted Chiropractor (or in case of Emergency Services, by a non-Contracted Chiropractor) for treatment or diagnosis of Neuromusculoskeletal Disorders and Pain syndromes. These services are limited to the management of Neuromusculoskeletal Disorders and Pain syndromes primarily through chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. This includes: (1) differential diagnostic examinations and related diagnostic X-rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; (2) the follow-up office visits which during the

course of treatment must include the provision of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Coinsurance is the percentage of the Covered Expenses, for which the Member is responsible, as specified in the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

Commercial Formulary 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. The Commercial Formulary is also referred to as “Recommended Drug List.” Some Drugs in the Commercial Formulary require Prior Authorization from Health Net in order to be covered.

Contracted Chiropractor means a chiropractor who is duly licensed to practice chiropractic in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Chiropractic Services to Members.

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

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Copayment is a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in the "Schedule of Benefits and Copayments – SELECT 1" and the "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" sections.

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

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 MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

CVS MinuteClinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the State of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

Deductible is a set amount you pay each Calendar Year for specified Covered Expenses before Health Net pays any benefits for those Covered Expenses.

Domestic Partner is for the purposes of this Evidence of Coverage, the Subscriber's partner if the principal Covered Person and partner are a couple who are domestic partners that meet all the requirements specified by section 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 SELECT Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the plan.

Emergency Care includes medical screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by an 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.

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

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

Emergency Chiropractic Services are covered services that are Chiropractic Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain, such that a person could reasonably expect that a delay of immediate Chiropractic Services could result in (1) placing 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)decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic Services. ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency Medical Condition. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Member or unborn child.

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 Chiropractic Services, "Experimental" services are chiropractic care that is an unproven chiropractic service that does not meet professionally recognized, valid, evidence-based standards of practice.

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

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this SELECT 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 SELECT Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this SELECT 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 SELECT is a comprehensive program that provides the Member with both medical insurance within a Preferred Provider organization network and out-of-Network Providers and health maintenance organization benefits through this *Evidence of Coverage* issued by Health Net.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members and provide benefits through approved health plans.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare Participating Provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in 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 the 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 female Member who has not yet gone through menopause:

- The Member has had coitus on a recurring basis for one year or more without use of contraception or other birth control methods which has not resulted in a pregnancy, or when a pregnancy did occur, a live birth was not achieved; or
- 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.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Amount is the amount on which Health Net bases its reimbursement for Covered Services and Supplies provided by a SELECT 3 (Out-of-Network Provider), which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the a SELECT 3 Provider or the amount determined as set forth below. Maximum Allowable Amount is not the amount that Health Net pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Evidence of Coverage*.

- ***Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care and outpatient pharmaceuticals***, received from a SELECT 3 Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this *Evidence of Coverage*.

  For illustration purposes only, SELECT 3 Provider: 70% Health Net Payment / 30% Covered Person Coinsurance:
  SELECT 3 Provider's billed charge for extended office visit $128.00
  MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount) $102.40
  Your Coinsurance is 30% of MAA: 30% x $102.40 (assumes Deductible has already been satisfied).....$30.72
  You also are responsible for the difference between the billed charge ($128.00) and the MAA amount ($102.40) $25.60
  Total amount of $128.00 charge that is your responsibility.....$56.32

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

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

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

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

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

- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits and Copayments – SELECT 1," "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3," "Covered Services and Supplies" and "Exclusions and Limitations" sections for specific benefit limitations, maximums, pre-Certification requirements and payment policies that limit the amount Health Net pays for certain Covered Services and Supplies. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the SELECT 3 Provider, Health Net may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, we may, at our option, refer a claim for SELECT 3 Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the SELECT 3 Provider. In either of these two circumstances, You will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the SELECT 3 level.

Note: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, Health Net will adjust, without notice, the Maximum Allowable Amount based on the CMS

schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the SELECT 3 Provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

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

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 Chiropractic Services, "Medically Necessary" services are Chiropractic Services which are necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

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

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

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

Member is the Subscriber or an enrolled Family Member.

Member Physician is a Physician who provides or authorizes services to a Health Net Member. Under SELECT 1, a Member Physician is an associate of a contracting Physician Group. Under SELECT 2, a Member Physician is a Preferred Provider.

Mental Disorders are syndromes characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflect a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Neuromusculoskeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders or biomechanical dysfunction of the joints of the body and/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 SELECT Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change contracting 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.

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-Network Providers are SELECT 3 Physicians, Hospitals, laboratories or other providers of health care who are not part of the Health Net SELECT 1 Health Maintenance Organization or SELECT 2 Preferred Provider Organization, except as specified under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

Out-of-Pocket Maximum is the maximum dollar amount of Coinsurance and Copayment for covered services for which the Member is responsible in a 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 and Coinsurance that were actually paid. Deductibles, Copayments and Coinsurance which are paid toward certain covered services are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in the "Out-of-Pocket Maximum – SELECT 1" and "Out-of-Pocket Maximum – SELECT 2 and SELECT 3" sections.

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.

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. Services provided at a facility under the SELECT 3 tier must meet these same licensing requirements.

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Disorder and Chemical Dependency rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section. Services provided by a Mental Health Professional under the SELECT 3 tier must meet these same licensing requirements.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this SELECT Plan.

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

- Dentist (D.D.S.)
- Optometrist (O.D.)
- Dispensing optician
- Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- Psychologist
- Chiropractor (D.C.)
- Nurse midwife
- Nurse Practitioner
- Physician Assistant

- Clinical social worker (M.S.W. or L.C.S.W.)
- Marriage, family and child counselor (M.F.C.C.)
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist*
- Audiologist*
- Occupational therapist (O.T.R.)*
- Psychiatric mental health nurse*
- Respiratory care practitioner

* Under SELECT 2 and SELECT 3 benefit level, services by these providers are covered only when a medical doctor (M.D.) or doctor of osteopathy (D.O.) refers the Member to them.

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*.

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

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug 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 Physician.

Preventive Care Services are services and supplies that are covered under the “Preventive Care Services” heading as shown in the “Schedule of Benefits and Copayments – SELECT 1,” "Schedule of Benefits and Copayments – SELECT 2 and SELECT 3" and "Covered Services and Supplies" sections. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health.
- Prevent or lower the risk of diseases or illnesses.
- Detect disease or illness in early stages before symptoms develop.

- Monitor the physical and mental development in children.

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. For the lowest office visit Copayment, you must visit your Primary Care Physician under SELECT 1.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" portion of "Covered Services and Supplies" for details regarding the prior authorization process relating to prescription drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a 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 who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional: (1) provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider; (2) is supervised by a Qualified Autism Service Provider; (3) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; (5) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; and (6) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

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 exists 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 under SELECT 1.

Specialty Drugs are identified in the Health Net Commercial Formulary 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.
- Are subject to limited distribution.

Specialty Drugs may be given orally, topically, by inhalation, or by self-injection (either subcutaneously, intramuscularly, or intravenously). A list of Specialty Drugs can be found in the Health Net Commercial Formulary on our website at www.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 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Commercial Formulary.

Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Commercial Formulary.

Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 in the Commercial Formulary, drugs indicated as "NF", if approved, or drugs not listed in the Commercial Formulary.

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. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Urgently Needed Care includes otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of 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 have known an emergency did not exist.

LANGUAGE ASSISTANCE SERVICES

Health Net provides free language assistance services, such as oral interpretation, translated written materials and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual staff and interpreter services for additional languages to handle Covered Person language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to Your health plan in the Covered Person's 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. Providers may not request that a Covered Person bring his or her own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day at all points of contact where a covered benefit or service is accessed. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for Health Care Services in such a manner that ensures the provision of interpreter services at the time of the appointment.

NOTICE OF LANGUAGE SERVICES

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088 (TTY: 711). If you bought coverage through the California marketplace call 1-888-926-4988 (TTY: 711). For more help: If you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية أو اتصل على مركز الاتصال التجاري في 1-800-522-0088 (TTY: 711). في حال قمت بشراء التغطية من سوق كاليفورنيا، اتصل على الرقم 1-888-926-4988 (TTY: 711) وللحصول على المساعدة: في حال كنت مسجلاً في بوليصة تأمين المنظمة المزودة المفضلة PPO أو المنظمة المزودة الحصرية EPO من شركة التأمين على الحياة Health Net Life Insurance Company ، اتصل على قسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. في حال كنت مسجلاً في منظمة المحافظة على الصحة HMO أو خطة التوفير الصحية HSP من شركة Health Net of California, Inc.,, اتصل على خط المساعدة في قسم الرعاية الصحية المدارة DMHC على الرقم 1-888-HMO-2219.

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-522-0088 (TTY: 711) հեռախոսահամարով: Եթե ապահովագրում եք գնել Կալիֆորնիայի շուկայական հրապարակի միջոցով, զանգահարեք 1-888-926-4988 (TTY: 711) հեռախոսահամարով: Լրացուցիչ օգնության համար. եթե անդամագրված եք Health Net Life Insurance Company-ի PPO կամ EPO ապահովագրությանը, զանգահարեք Կալիֆորնիայի Ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով: Եթե անդամագրված եք Health Net of California, Inc.-ի HMO կամ HSP ծրագրին, զանգահարեք DMHC օգնության գիծ՝ 1-888-HMO-2219 հեռախոսահամարով:

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-522-0088（TTY：711）。如果您是透過加州健康保險交易市場購買承保，請致電 1-888-926-4988（TTY：711）。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi
बिना लागत वाली भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-522-0088 (TTY: 711) पर कॉल करें। यदि आपने कैलिफोर्निया मार्किट प्लैस के माध्यम से कवरेज खरीदा है तो 1-888-926-4988 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company पीपीओ PPO या ईपीओ EPO बीमा पॉलिसी में नामांकित हैं, तो कैलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc. के एचएमओ HMO या एचएसपी HSP प्लैन में नामांकित हैं, तो डीएमएचसी DMHC हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Kev pab, hu rau peb ntawm tus xov tooj teev nyob rau hauv koj daim ID card los yog hu rau 1-800-522-0088 (TTY: 711). Yog tias koj yuav kev pov hwm ntawm California marketplace hu 1-888-926-4988 (TTY: 711). Xav tau kev pab ntxiv: Yog koj tau tsab ntawv tuav pov hwm PPO los yog EPO los ntawm Health Net Life Insurance Company, hu mus rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj tau txoj kev pab kho mob HMO los yog HSP los ntawm Health Net of California, Inc., hu mus rau DMHC tus xov tooj pab Helpline ntawm 1-888-HMO-2219.

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-522-0088、(TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイス（保険購入サイト）を通じて保険を購入された方は、1-888-926-4988 (TTY: 711) 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のPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局 1-800-927-4357 まで電話でお問い合わせください。Health Net of California, Inc.のHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន 1-800-522-0088 (TTY: 711)។ បើសិនអ្នកបានទិញការធានារ៉ាប់រងតាមរយៈ ទីផ្សារនៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទូរសព្ទទៅលេខ 1-888-926-4988 (TTY: 711)។ សម្រាប់ជំនួយបន្ថែម ៖ បើសិនអ្នកបានចុះឈ្មោះក្នុងគោលការណ៍ធានារ៉ាប់រង PPO ឬ EPO ពីក្រុមហ៊ុនធានារ៉ាប់រងជីវិត Health Net Life Insurance Company សូមទាក់ទងទៅនាយកដ្ឋានធានារ៉ាប់រង CA តាមរយៈទូរសព្ទលេខ 1-800-927-4357។ បើសិនអ្នកបានចុះឈ្មោះក្នុងផែនការ HMO ឬ HSP ពីក្រុមហ៊ុន Health Net of California, Inc. នៃរដ្ឋកាលីហ្វ័រញ៉ា សូមទាក់ទងលេខទូរសព្ទជំនួយ DMHC ៖ 1-888-HMO-2219។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나1-800-522-0088 (TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스를 통해 보험을 구입하셨으면 1-888-926-4988 (TTY: 711) 번으로 전화해 주십시오. 추가 도움이 필요하시면, Health Net Life Insurance Company의 PPO 또는 EPO 보험에 가입되어 있으시면 캘리포니아 주 보험국에 1-800-927-4357번으로 전화해 주십시오. Health Net of California, Inc.의 HMO 또는 HSP 플랜에 가입되어 있으시면 DMHC 도움라인에 1-888-HMO-2219번으로 전화해 주십시오.

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-522-0088 (TTY: 711). California marketplace hoolyéhíjí béeso ách'ą́ą́h naanilí ats'íís baa áháyą́ biniiyé nahínółnii'go éí kojį' hólne' 1-888-926-4988 (TTY: 711). Shíká anáá'doowoł jinízingo: PPO éí doodaii' EPOǫjí Health Net Life Insurance Company wolyéhíjí béeso ách'ą́ą́h naa'nil biniiyé hwe'iina' bik'é'ésti'go éí CA Dept. of Insurance bich'į' hojilnih 1-800-927-4357. HMO éí doodaii' HSPǫjí Health Net of California, Inc.ǫjí béeso ách'ą́ą́h naa'nil biniiyé hats'íís bik'é'ésti'go éí kojį' hojilnih DMHC Helpline 1-888-HMO-2219.

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد به زبان شما برایتان قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید، یا درخواست کنندگان گروه کارفرما لطفاً با مرکز تماس بازرگانی1-800-522-0088 (TTY: 711) تماس بگیرید. درخواست کنندگان برنامه انفرادی یا خانواده (IFP) لطفاً با شماره1-877-609-8711 (TTY: 711) تماس بگیرید. برای دریافت راهنمایی بیشتر: اگر در بیمه نامه PPO یا EPO از سوی Health Net Life Insurance Company عضویت دارید، با CA Dept. of Insurance به شماره 1-800-927-4357 تماس بگیرید. اگر در برنامه HMO یا HSP از سوی Health Net of California, Inc عضویت دارید، با خط راهنمایی تلفنی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਾਰਿਵਾਰਕ ਪਲੈਨ (IFP) ਦੇ ਆਵੇਦਕ ਕਿਰਪਾ ਕਰਕੇ 1-877-609-8711 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਵਧੇਰੀ ਮਦਦ ਲਈ: ਜੇ Health Net Life Insurance Company ਤੋਂ ਇੱਕ ਪੀਪੀਓ PPO ਜਾਂ ਈਓਪੋ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ, ਤਾਂ ਕੈਲੀਫੋਰਨੀਆਂ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਹੈਲਥ ਨੈੱਟ ਆਫ਼ ਕੈਲੀਫ਼ੋਰਨੀਆਂ, ਇੰਕ ਤੋਂ ਇੱਕ ਐਚਐਮਓ HMO ਜਾਂ ਐਚਐਸਪੀ HSP ਪਲੈਨ ਵਿੱਚ ਨਾਮਾਂਕਿਤ ਹੋ ਤਾਂ ਡੀਐਮਐਚਸੀ DMHC ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы в переводе на ваш родной язык. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником группового плана, предоставляемого работодателем, звоните в коммерческий контактный центр компании 1-800-522-0088 (TTY: 711). Если вы хотите стать участником плана для семей и частных лиц (IFP), звоните по телефону 1-877-609-8711 (TTY: 711). Дополнительная помощь: Если вы включены в полис PPO или EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхования штата Калифорния CA Dept. of Insurance, телефон 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., звоните по контактной линии Департамента управляемого медицинского обслуживания (DMHC), телефон 1-888-HMO-2219.

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación. Los solicitantes del grupo del empleador deben llamar al 1-800-522-0088 (TTY: 711). Los solicitantes de planes individuales y familiares deben llamar al 1-877-609-8711 (TTY: 711). Para obtener más ayuda, haga lo siguiente: Si está inscrito en una póliza de seguro PPO o EPO de Health Net Life Insurance Company, llame al Departamento de Seguros de California, al 1-800-927-4357. Si está inscrito en un plan HMO o HSP de Health Net of California, Inc., llame a la línea de ayuda del Departamento de Atención Médica Administrada, al 1-888-HMO-2219.

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card, o para sa grupo ng mga aplikante ng employer, mangyaring tawagan ang 1-800-522-0088 (TTY: 711). Para sa mga aplikante ng Plano para sa Indibiduwal at Pamilya Individual & Family Plan, (IFP), mangyaring tawagan ang 1-877-609-8711 (TTY: 711). Para sa higit pang tulong: Kung nakatala kayo sa insurance policy ng PPO o EPO mula sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung nakatala kayo sa HMO o HSP na plan mula sa Health Net of California, Inc., tawagan ang Helpline ng DMHC sa 1-888-HMO-2219.

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ ผู้สมัครกลุ่มนายจ้าง กรุณาโทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711) ผู้สมัครแผนบุคคลและครอบครัว Individual & Family Plan (IFP) กรุณาโทร 1-877-609-8711 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทำกรมธรรม์ประกันภัย PPO หรือ EPO กับ Health Net Life Insurance Company โทรหากรมการประกันภัยรัฐแคลิฟอร์เนียได้ที่ 1-800-927-4357 หากคุณสมัครแผน HMO หรือ HSP กับ Health Net of California, Inc. โทรหาสายด่วนความช่วยเหลือของ DMHC ได้ที่ 1-888-HMO-2219.

Vietnamese

Các Dị ch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị, hoặc người nộp đơn vào chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi 1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia Đình viết tắt trong tiếng Anh là (IFP) vui lòng gọi số 1-877-609-8711 (TTY: 711). Để nhận thêm trợ giúp: Nếu quý vị đăng ký hợp đ ồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Sở Y Tế CA theo số 1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc., vui lòng gọi Đường Dây Trợ Giúp DMHC theo số 1-888-HMO-2219.

NOTICE OF NONDISCRIMINATION

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

IFP On Exchange/Covered California 1-888-926-4988 (TTY: 711)

IFP Off Exchange 1-800-839-2172 (TTY: 711)

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on the characteristics above, you can file a grievance by calling Health Net's Customer Contact Center at the numbers above and telling them you need help filing a grievance. Health Net Customer Contact Center is available to help you. You can also file a grievance by mail, fax or e-mail at:

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

Fax: 1-877-831-6019

E-mail: Member.Discrimination@healthnet.com

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Contact us

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

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

www.healthnet.com

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