Evidence of Coverage and Plan Document

A complete explanation of your Plan

HMO (Plan NB0)

Important benefit information – please read

Dear Health Net Member:

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

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

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

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 at1-888-893-1572. Our Customer Contact Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

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

Thank you for choosing Health Net.

ABOUT THIS BOOKLET

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

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

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

Method of Provider Reimbursement

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

Use of Special Words

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

The following words are used frequently:

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

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INTRODUCTION TO HEALTH NET

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

How to Obtain Care

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

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Customer Contact Center at 1-888-893-1572 to ensure that you can obtain the Health Care Services that you need.

Transition of Care for New Members

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

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the Member's Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or

- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

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

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

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

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

Selecting a Primary Care Physician

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

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

Selecting a Contracting Physician Group

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

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

Selecting a Participating Mental Health Professional

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

Routine outpatient therapy and medication management visits with an in-network provider do not require Prior Authorization nor referral from a Primary Care Physician. Certain services and supplies for Mental Health and Substance Use Disorders may require Prior Authorization by Health Net in order to be covered. Upon request, the criteria used to review the Prior Authorization request, and any education program materials used to develop these criteria, will be provided to you at no cost. This information is available online at our website at www.healthnet.com. You can also call the Health Net Customer Contact Center at the telephone number on your Health Net ID card to request the information

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

Specialists and Referral Care

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

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

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

Standing Referral to Specialty Care for Medical and Surgical Services

A standing referral is a referral to a participating Specialist for more than one visit without your Primary Care Physician having to provide a specific referral for each visit. You may receive a standing referral to a Specialist if your continuing care and recommended treatment plan is determined Medically Necessary by your Primary Care Physician, in consultation with the Specialist, Health Net's Medical Director and

you. The treatment plan may limit the number of visits to the Specialist, the period of time that the visits are authorized or require that the Specialist provide your Primary Care Physician with regular reports on the health care provided. Extended access to a participating Specialist is available to Members who have a Life Threatening, degenerative or disabling condition (for example, Members with HIV/AIDS). To request a standing referral ask your Primary Care Physician or Specialist.

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

Changing Contracting Physician Groups

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

Your Financial Responsibility

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

Questions

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

Timely Access to Care

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

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with Your Primary Care Physician

When you need to see your Primary Care Physician (PCP), call their office for an appointment at the phone number on your Health Net ID 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:

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Urgent care appointment with non-Physician behavioral HealthCare Provider or behavioral health care Physician (psychiatrist) that does not require Prior Authorization:** within 48 hours of request.
- **Urgent care appointment with non-Physician behavioral Health Care Provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization:** within 96 hours of request.
- **Nonurgent appointment with behavioral Health Care Physician (psychiatrist):** within 15 business days of request.

- **Nonurgent appointment with non-Physician behavioral Health Care Provider:** within 10 business days of request.
- **Nonurgent follow-up appointment with non-Physician mental Health Care Provider (NPMH):** within 10 business days of request.
- **Non-Life -Threatening behavioral health emergency:** within 6 hours of request for an appointment.
- **Life-threatening behavioral health emergencies:** require immediate intervention and treatment.

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

Scheduling Appointments with a Specialist for Medical and Surgical Services

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

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

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

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

Scheduling Appointments for Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

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

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

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL OR MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE IMMEDIATELY
In serious emergency situations: Call "**911**" or go to the nearest Hospital.

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

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

Except in an emergency or other urgent circumstances:

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

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

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

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Services and 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 Services and Care or Urgently Needed Care. Authorization is not mandatory to secure coverage. See the "Definitions Related to Emergency and Urgently Needed Care" section below for the definition of Urgently Needed Care.

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

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

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

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

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

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

Definitions Related to Emergency Services and Care and Urgently Needed Care

Please refer to the "Definitions" section for definitions of Emergency Services and 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 Services and Care or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the

drug less any required Copayment shown in the "Schedule of Benefits and Copayments" section. You will have to pay for the Prescription Drug when it is dispensed.

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

Note(s):

The Prescription Drugs/Outpatient Prescription Drugs" exclusion in the "Exclusions and Limitations" section and the requirements of the 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 Benefits 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.

Acupuncture Services

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

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

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

Because ASH Plans arranges only Acupuncture Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling "**911**." You are encouraged to use appropriately the "**911**" emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

SCHEDULE OF BENEFITS AND COPAYMENTS

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

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

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

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

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

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

	Copayment
Use of emergency room (facility and professional services)	$75
Use of urgent care center (facility and professional services)	$35

Copayment Exception(s):

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

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

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

	Copayment
Use of emergency room (facility and professional services)	$75
Use of urgent care center (facility and professional services)	$10

Copayment Exception(s):

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

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

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

	Copayment
Ground ambulance	$0
Air ambulance	$0

Note(s):

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

Ambulance Services (Mental Health or Substance Use Disorders)

	Copayment
Ground ambulance	$0
Air ambulance	$0

Note(s):

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

Office Visits

	Copayment
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group	$10
Specialist or specialty care consultation*	$10
Visit to CVS MinuteClinic*	$10
Primary Care Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$10
Specialist visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$10
Vision examinations including refractive eye examinations by an ophthalmologist	$10
Vision examinations including refractive eye examinations by all other providers including optometrists	$10
Hearing examinations for hearing loss by an otolaryngologist	$10
Hearing examinations for hearing loss by all other providers including audiologists	$10
Telehealth consultation through the Select Telehealth Services Provider**	$0

Note(s):

Self-referrals are allowed for obstetrician, gynecological services, and reproductive and sexual Health Care Services. (Refer to "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. Preventive Care Services through the CVS MinuteClinic are subject to the Copayment shown below under "Preventive Care Services."

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

Preventive Care Services

	Copayment
Preventive Care Services*	$0

Note(s):

Covered Benefits 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), breastfeeding support and supplies (including one breast pump per pregnancy), and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Covered Services and Supplies" section, for details.

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

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

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Note(s):

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

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$0
Allergy injection services	$0
Allergy serum	$0

Immunizations for occupational purposes or foreign travel 20%
Injections
Office based injectable medications - administration (per dose).....$0
Office based injectable medications - injected substance (per dose).....$0

Note(s):

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

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

Rehabilitation and Habilitation Therapy

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

Note(s):

These services will be covered when Medically Necessary.

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

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit*	$10
Newborn care office visit (birth through 30 days)	$10
Physician visit to the mother or newborn at a Hospital**	$0
Normal delivery, including cesarean section	$0
Circumcision of newborn (birth through 30 days)***	$0

Note(s):

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 Facility Services" headings to determine any additional Copayments that may apply. Genetic testing is covered as a laboratory service as shown under the "Other Professional Services"

heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.

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

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

** One Copayment per visit.

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

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male	$0

Note(s):

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 Facility Services" headings to determine any additional Copayments that may apply.

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

Infertility Services

	Copayment
Infertility services (all Covered Benefits that diagnose, evaluate or treat Infertility)	See note below*

Note(s):

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

Infertility services (which include GIFT, IVF, and ZIFT limited to 3 completed oocyte retrieval cycles per lifetime) and all Covered Benefits that prepare the Member to receive this procedure, are covered only for the Health Net Member.

Refer to the "Infertility Services" and "Fertility Preservation" provisions in the "Covered Services and Supplies" section for additional information.

* Applicable Copayment requirements apply to any services and supplies required for Infertility services. For example, if the Infertility service requires an office visit, then the office visit Copayment will apply.

Other Professional Services

	Copayment
Surgery	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Assistance at surgery	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Administration of anesthetics	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Chemotherapy	$0
Radiation therapy	$0
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Laboratory services	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Diagnostic imaging (including x-ray) services	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
CT, SPECT, MRI, MUGA and PET	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Medical social services	$0
Patient education*	$0
Nuclear medicine (use of radioactive materials)	$0
In an inpatient setting	$0
In a Physician's office or outpatient facility	$0
Renal dialysis	$0
Organ, tissue or stem cell transplants	See note below**
Infusion therapy***	
In a home	$0
In an office or outpatient setting	$10

Note(s):

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

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

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

** Applicable Copayment requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment will apply.

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

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers including face masks and tubing*	$0
Orthotics (such as bracing, supports and casts)	$0
Diabetic equipment**	$0
Corrective Footwear (for the treatment of conditions related to diabetes)	$0
Prostheses (internal or external)***	$0
Blood or blood products except for drugs used to treat hemophilia, including blood factors	$0
Drugs used to treat hemophilia, including blood factors****	$0

Note(s):

* For coverage information, please see "Durable Medical Equipment" in the "Covered Services and Supplies" section. 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.

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

***Prostheses include coverage of ostomy and urological supplies. See "Ostomy and Urological Supplies" portion of the "Covered Services and Supplies" section.

****Drugs for the treatment of hemophilia, including blood factors are also covered 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	$10 per visit

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

Note(s):

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

Outpatient Facility Services

	Copayment
Outpatient facility services (other than surgery)	$0
Outpatient surgery (surgery performed in a Hospital outpatient setting 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 or physical therapy are subject to the same Copayment which is required when these services are performed at your Physician's office.

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

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

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

Skilled Nursing Facility Services

	Copayment
Room and board in a semi-private room with ancillary (additional) services	$0

Limitation(s):

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

Mental Health or Substance Use Disorder Benefits

Mental Health	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)*	$10
Outpatient group therapy session	$5
Outpatient services other than an office visit/professional consultation (including psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) and other outpatient services including, but not limited to, laboratory services or re-habilitation when provided for a Mental Health or Substance Use Disorder condition)**	$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 Health Net)	$10
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

Substance Use Disorders	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)*	$10
Outpatient group therapy session	$5
Outpatient services other than an office visit/professional consultation (including psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) and other outpatient services including, but not limited to, laboratory services or rehabilitation when provided for a Mental Health or Substance Use Disorder condition)**	$0
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

Participating Mental Health Professional visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net) $10

Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center on an inpatient basis $0

Exception(s):

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

Note(s):

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

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

Prescription Drugs

	Copayment

Retail Pharmacy (up to a 30 day supply)

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs $10

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost. $20

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier $35

Lancets $0

Sexual dysfunction drugs (including self-injectable drugs) 50%

Weight loss drugs for the treatment of obesity (including self-injectable drugs) 50%

Infertility drugs (including self-injectable drugs) ..... See note below*

Preventive drugs and 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 low-cost preferred Brand Name Drugs $20

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost. $40

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier $70

Lancets $0

Preventive drugs and contraceptives $0

Notes:

* Infertility drugs are subject to the applicable Tier 1, 2, 3 or Specialty Drug tier Copayment shown above under "Retail Pharmacy."

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 Formulary, please call the Customer Contact Center at the telephone number on your ID card or visit our website at www.healthnet.com to view the Formulary.

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

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

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

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

Prior Authorization:

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

Copayment Exception(s):

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

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
- 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 Contraceptives:

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section, for additional details. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

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. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

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

Diabetic Supplies:

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

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

Sexual Dysfunction Drugs:

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to quantities as specified in Health Net's Formulary. For information about Health Net's 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(s):

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. (combined with office visits to the Contracted Acupuncturist).

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(s):

Up to a maximum of $50 is covered for each Member during a Calendar Year for covered Chiropractic Appliances. (combined with office visits to the Contracted Chiropractor).

Acupuncture Services

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

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

Notes:

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

Limitations:

Up to 20 office visits to a Contracted Acupuncturist during a Calendar Year are covered.

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

OUT-OF-POCKET MAXIMUM

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

Once the total amount of all Deductibles and Copayments you pay for Covered Benefits under this *Evidence of Coverage* in any one Calendar Year equals the "Out-of-Pocket Maximum" amount, no payment for Covered Benefits may be imposed on any Member, except as described in "Exceptions to OOPM" below.

OOPM for Medical Benefits

The OOPM amounts for medical benefits, including Covered Benefits provided by American Specialty Health Plans of California, Inc. (ASH Plans), are:

One Member $1500
Two Members $3000
Family (three or more Members) $4500

OOPM for Outpatient Prescription Drug Benefits

The OOPM amounts for this Plan are:

One Member $2000
Family (two or more Members) $4000

Exceptions to OOPM:

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

The following Copayments or expenses paid by you for Covered Benefits under this Plan will not 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 the Mail Order Program" provision of the "Prescription Drugs" subsection of the "Covered Services and Supplies," section and any cost differential between brand/generic medications when dispensing Brand Name Drugs not based on medical necessity.
- Services from a CVS MinuteClinic that are not otherwise covered under this Plan. Please refer to the "Covered Services and Supplies," section for additional information.

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

Note(s):

All Specialty Drugs will be applied to the Pharmacy OOPM.

How the OOPM Works

Keep a record of your payment for Covered Benefits.

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

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

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who is Eligible for Coverage

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

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

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

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

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

Age Limit for Children

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

Disabled Child

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

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

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

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

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

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

- Within the first two years following the child's reaching the age limit, you may be asked to provide proof as may be required by Health Net.
- After this two-year period, Health Net may require proof no more frequently than once a year.
- A disabled child may remain covered by this Plan for as long as they remain incapacitated and continue to meet the eligibility criteria described above.

How to Enroll for Coverage

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

Employee

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

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

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

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

Eligible employees who enroll in this Plan are called Subscribers.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse (and your spouse's eligible children) within 30 days of the date of marriage. Coverage begins on the first day of the calendar month following the date the application for coverage is received.

Domestic Partner: If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may enroll your new Domestic Partner (and their eligible children) within 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 their spouse will automatically be covered for 31 days (including the date of birth). If you do not enroll the newborn within 31 days (including the date of birth), they are covered for only the 31 days starting on and including the day of birth.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in "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 their spouse, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 30 days from the date of eligibility. The child will be assigned to the Subscriber's Physician Group. 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 "Transferring to Another Contracting Physician Group" portion of this section.

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

Legal Ward (Guardianship): If the Subscriber or spouse becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 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, this Plan will cover the remainder of that confinement only if you inform the Customer Contact Center upon your Effective Date about the confinement.

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

Totally Disabled on Your Effective Date

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

For the purposes of coordinating benefits under this *Evidence of Coverage*, if you are entitled to an extension of benefits from your prior group health plan, and state law permits such arrangements, your prior group health plan shall be considered the Primary Plan (paying benefits first) and benefits payable

under this *Evidence of Coverage* shall be considered the secondary plan (paying any excess covered expenses), up to 100% of total covered expenses.

Late Enrollment Rule

Health Net's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for coverage, they 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 employer should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

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

Exceptions to Late Enrollment Rule

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

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

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

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

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 Plan

If you are covered by this 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 Plan

If you previously declined enrollment in this Plan because of other group coverage, and you gain a new dependent due to childbirth, marriage, adoption or placement for adoption, you can enroll yourself and the dependent within 30 days of birth, marriage, adoption or placement for adoption.

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

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

If you do not enroll yourself, the new dependent and any other Family Members within 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 the 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 their 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.

Notes:

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

While you have 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 pursuant to Public Law 107-243 or Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

Special Reinstatement Rule under USERRA

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

Transferring to Another Contracting Physician Group

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

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

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

  Exceptions:

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

Effective Date of Transfer

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

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

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

When Coverage Ends

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

All Group Members

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

Termination for Nonpayment of Subscription Charges

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

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

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

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

Termination for Loss of Eligibility

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

- The Member no longer meets the eligibility requirements established by the Group and Health Net. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:
  1. The date established by the order.
  2. The date the order expired.
- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to the Subscriber only because of the marriage, will end.

When the Member ceases to reside in the 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 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 Service Area will be limited to services provided in connection with Emergency Services Care or Urgently Needed Care. Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by Health Net.

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

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

Termination for Cause

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

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

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

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

How to Appeal Your Termination

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

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

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

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

Coverage Options Following Termination

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

- **COBRA Continuation Coverage:** Many groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with your Group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue Group coverage under this *Evidence of Coverage* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

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

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

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

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

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

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

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

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

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

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

1. You have been covered for 36 months from your original COBRA effective date (under this or any other plan).*
2. The Member becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Member moves outside the Service Area.

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

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

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

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

Extension of Benefits

When Benefits May Be Extended

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

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

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

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

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

How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a

written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

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

When the Extension Ends

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

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

COVERED SERVICES AND SUPPLIES

This Plan covers services or supplies provided from the Effective Date of coverage through midnight of the effective date of cancellation, 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.

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

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

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

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

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

Medical Services and Supplies

Office Visits

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

CVS MinuteClinic Services

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

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

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

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

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

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

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

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

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

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

Preventive Care Services

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

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

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

- Guidelines for women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)

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

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) recommended cancer screenings, including cervical cancer screening (including human papillomavirus (HPV) screening), screening for prostate cancer (including prostate-specific antigen testing and digital rectal examinations) , lung cancer, and colorectal cancer screening (e.g., colonoscopies)
- Breast cancer screening (mammograms, including three-dimensional (3D) mammography, also known as digital breast tomosynthesis). Additional breast imaging (e.g., MRI, ultrasound) and pathology evaluation is covered if additional imaging is indicated to complete the screening process
- Human Immunodeficiency Virus (HIV) testing and screening
- Pre-Exposure Prophylaxis (PrEP) medications for the prevention of HIV infection including related medical services - baseline and follow-up testing and ongoing monitoring (e.g., HIV testing, kidney function testing, serologic testing for hepatitis B and C virus, testing for other sexually transmitted infections, pregnancy testing when appropriate and adherence counseling)
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use
- Routine immunizations to prevent diseases and infections, as recommended by the ACIP (e.g., chickenpox, measles, polio, meningitis, mumps, flu, pneumonia, shingles, or HPV)
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Anxiety screening for children, adolescents, and adults
- Regular well-baby and well-child visits
- Well-woman visits

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

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

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

COVID-19 Outpatient Services

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

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

The cost shares above apply to these listed services only.

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment, including refractive eye examinations, are covered as shown in the "Schedule of Benefits and Copayments" section. Preventive vision and hearing screening are covered as Preventive Care Services. The plan does not cover vision therapy, eyeglasses or contact lenses. However, implanted lenses that replace organic eye lenses are covered.

Refractive Eye Surgery

This Plan covers eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) or astigmatism, only when Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net.

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 covered only when Medically Necessary. Additionally, treatment for cramping of the feet, bunions and muscle trauma are covered only when Medically Necessary

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

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

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

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

Self-Referral for Reproductive and Sexual Health Care Services

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

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

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

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

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

Treatment Related to Rape or Sexual Assault

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

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

Immunizations and Injections

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

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

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

Surgical Services

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

Surgically Implanted Drugs

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

Gender Affirming Surgery

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

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Biomarker testing is covered when determined by Health Net to be Medically Necessary, including for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. However, Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer.

Genetic testing will not be covered for nonmedical reasons or when a Member has no medical indication. For information regarding genetic testing and diagnostic procedures of a fetus, see the "Pregnancy" portion of the "Covered Services and Supplies" section.

Home Visit

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

Rehabilitation Therapy

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

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contracted Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical conditions and Mental Health or Substance Use Disorders, or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the Plan or the Member's Physician Group. The services must be based on a treatment plan authorized, as required by the Plan or the Member's Physician Group. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See the "General Provisions" section for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

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

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

This Plan covers massage therapy only when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group.

Habilitative Services

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

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

Cardiac Rehabilitation Therapy

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

Pulmonary Rehabilitation Therapy

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

Approved 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. Approved Clinical Trial services performed by nonparticipating providers are covered only when the protocol for the trial is not available through a participating provider within California. Services rendered as part of a clinical trial may be provided by a nonparticipating or participating provider subject to the reimbursement guidelines as specified in the law.

"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 an Approved Clinical Trials program.

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

Please refer to the "Exclusions and Limitations" section for more information.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered. Prenatal diagnostic procedures include services provided by the California Prenatal Screening Program administered by the California Department of Public Health and are covered at no cost to the Members. The California Prenatal Screening Program is a statewide program offered by prenatal care providers to all pregnant individuals in California. Prenatal screening uses a pregnant individual's blood samples to screen for certain birth defects in their fetus. Prenatal screenings must be performed at or through a PNS-contracted lab. Individuals with a fetus found to have an increased chance of one of those birth defects are offered genetic counseling and other follow-up services through state-contracted Prenatal Diagnosis Centers.

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

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

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

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

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

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

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

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

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

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

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

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

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

Family Planning

This Plan covers counseling and planning for contraception, fitting examination for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

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

Infertility Services

Medically Necessary Infertility services are covered when a Member and/or the Member's partner is infertile (refer to Infertility in the "Definitions" section). If one partner does not have Health Net coverage, Infertility services are covered only for the Health Net Member.

Covered Benefits include:

- Office visits, laboratory services, professional services, inpatient and outpatient services;
- Prescription Drugs;
- Treatment by injections;
- Artificial insemination;
- In-vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete Intrafallopian Transfer (GIFT); and
- Related processes or supplies that are Medically Necessary to prepare the Member to receive the covered Infertility treatment, including oocyte retrieval and embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

Infertility services do not include:

- Collection or storage of gamete or embryo unless Medically Necessary to prepare the Member to receive the covered Infertility treatment;
- Purchase of sperm or ova;
- Oocyte retrievals after the lifetime maximum of 3 completed oocyte retrieval cycles have been met.

Infertility services are subject to the Copayments and benefit limitations, as shown under "Infertility Services" and "Prescription Drugs" in the "Schedule of Benefits and Copayments" section.

Treatment of Infertility and fertility services are covered without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

Fertility Preservation

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

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

Coverage for fertility preservation does not include the following:

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

Medical Social Services

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

Patient Education

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

Services for Educational or Training Purposes

Except for services related to behavioral health treatment for pervasive development disorder or autism which are covered as shown in this section, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a Health Care Provider by the state of California. Examples of excluded services include education and training for nonmedical purposes such as:

- Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. For example: The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching Members how to read; educational testing or academic education during residential treatment.

- Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
- Teaching manners or etiquette appropriate to social activities.
- Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for behavioral health treatment as indicated above in conjunction with the diagnosis of pervasive development disorder or autism.

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 Net and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

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

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

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

Outpatient Infusion Therapy

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

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

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

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

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

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

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

Ambulance Services

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

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

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 Services and Care were not met, unless authorized by your Physician Group; 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.

Nonemergency ambulance services are covered when Medically Necessary and when your condition requires the use of services that only a licensed ambulance can provide when the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

Hospice Care

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

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

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

Durable Medical Equipment

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

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

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

- The Corrective Footwear is Medically Necessary;

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

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

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. In assessing medical necessity for Durable Medical Equipment (DME) coverage, Health Net applies nationally recognized DME coverage guidelines such as those defined by InterQual (McKesson) and the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

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

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

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

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

Diabetic Equipment

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

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

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

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

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

Bariatric (Weight Loss) Surgery

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

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

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

Approved travel-related expenses will be reimbursed as follows:

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

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

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

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

Treatment of Obesity

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

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

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

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

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.

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 a laryngectomy and visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

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

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

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

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

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

Ostomy and Urological Supplies

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

- Ostomy adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles – bedside and leg
- Dressing supplies
- Irrigation supplies
- Lubricants

- Miscellaneous supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches - urinary. drainable, ostomy
- Rings - ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and nonwaterproof.

Blood

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

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 an Experimental Service or Investigational Service.

Inpatient Hospital Confinement

Covered Benefits include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary;
- Physician services;
- Specialized and critical care;
- General nursing care;
- Special duty nursing as Medically Necessary;
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services;

- Durable Medical Equipment and supplies;
- Medical social services;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products are covered; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

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

Outpatient Hospital Services

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

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

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

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

Reconstructive Surgery

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

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

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

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

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

Dental Services

Dental services or supplies are limited to the following situations:

- When immediate Emergency Services and 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 noncovered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this Evidence of Coverage, and will only be covered under the following circumstances (a) Members who are under eight years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- For acupuncture treatment of postoperative dental Pain, but only when Acupuncture Services are covered under this Plan through American Specialty Health Plans of California, Inc. (ASH Plans).

The following services are not covered under any circumstances, except as 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.
- Drugs prescribed for routine dental treatment.

Disorders of the Jaw

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

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

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

Skilled Nursing Facility

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

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

- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

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

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

Phenylketonuria (PKU)

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

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

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

Vitamins and Nutritional Supplements

Prescription vitamins and nutritional supplements listed in the Health Net Formulary are covered. Other specialized formulas and nutritional supplements, including vitamins and herbal remedies, are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

To request an authorization for a second opinion, contact your Primary Care Physician or the Customer Contact Center at the telephone number on your Health Net ID card. Physicians at your Physician Group

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

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

Telehealth Services

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

Telehealth Consultations Through the Select Telehealth Services Provider

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

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

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

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

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

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

Mental Health or Substance Use Disorders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transition of Care for New Members

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

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

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

The following benefits are provided:

Outpatient Services

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

Covered Benefits include:

- Outpatient office visits/professional consultation including Substance Use Disorders: Includes outpatient crisis intervention, short-term evaluation and therapy, medication management (including detoxification), drug therapy monitoring, longer-term specialized therapy, and individual and group Mental Health and Substance Use Disorder evaluation and treatment.
- Outpatient services other than an office visits/professional consultation including Substance Use Disorders: Including psychological and neuropsychological testing when necessary to evaluate a Mental Health or Substance Use Disorder, intensive outpatient care program, day treatment and partial hospitalization program and other outpatient procedures/services including, but not limited to, laboratory services or rehabilitation when provided for Mental Health or Substance Use Disorder conditions. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. Partial hospitalization/day treatment program is a treatment program that may be freestanding or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral health treatment for pervasive developmental disorder or autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with pervasive developmental disorder or autism, as shown in the "Schedule of Benefits and Copayments" section under "Mental Health or Substance Use Disorder Benefits."
  - The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.
  - A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to Health Net.

- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

- **Note:** All services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a Health Care Provider by the state of California. Examples of excluded services include education and training for nonmedical purposes such as:
  - Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. For example: The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching Members how to read; educational testing or academic education during residential treatment.
  - Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
  - Teaching manners or etiquette appropriate to social activities.
  - Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for behavioral health treatment as indicated above in conjunction with the diagnosis of pervasive development disorder or autism.

Second Opinion

You may request a second opinion when:

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

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

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

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

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

Inpatient Services

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

Covered Benefits 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 .
- 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;

Detoxification and Treatment of Withdrawal Symptoms

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

Transitional Residential Recovery Services

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

Aversion Therapy

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

Psychological Testing

Psychological testing is only covered when conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. The scoring of automated computer-based reports is only covered when performed by a provider qualified to perform it.

Biofeedback

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

Nonstandard Therapies

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

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

Treatment Related to Judicial or Administrative Proceedings

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

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

Prescription Drugs

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

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

Covered Drugs and Supplies

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

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

Tier 1 and Tier 2 Drugs listed in the Health Net Formulary are covered, when dispensed by Participating Pharmacies and prescribed by a Physician from your selected Physician Group, an authorized referral Specialist or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net in order to be covered. The fact that a drug is listed in the 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 Formulary; or
- Not listed in the Health Net Formulary and 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 "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" section.

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
   A. The drug is prescribed by a participating licensed health care professional for the treatment of a Life-Threatening condition; OR

B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and Seriously Debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the 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 DrugDex; OR
   C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Diabetic Drugs and Supplies

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

Drugs and Equipment for the Treatment of Asthma

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

Compounded Drugs

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

for compounded drugs requires the Tier 3 Drug Copayment, must be obtained from a Participating Pharmacy and is subject to Prior Authorization by the Plan and medical necessity.

Diagnostic Drugs

Diagnostic drugs are covered under the medical benefit when Medically Necessary. Drugs used for diagnostic purposes are not covered as a part of the Prescription Drug benefit.

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.

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

Preventive Drugs and Contraceptives

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member. 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 available with a Prescription Drug Order. Contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal and emergency contraceptives and condoms. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Formulary.

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

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

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

Weight Loss Drug

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

The Formulary

What Is the Health Net Formulary?

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

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

How Are Drugs Chosen for the Health Net Formulary?

The Formulary is created and maintained by the Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the 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 Formulary. The Formulary is updated as new clinical information and medications are approved by the FDA.

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

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

Step Therapy

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

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the Prescription Drug prescribed by a Health Care Provider for an individual enrollee. For more information on the step therapy exception process please see “Step Therapy Exception” in the Formulary on www.healthnet.com.

Prior Authorization and Step Therapy Exception Process for Prescription Drugs

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

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

Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted.

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

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

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

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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

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

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

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

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

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

Except as described below in "Nonparticipating Pharmacies and Emergencies," for new Members and emergent care, if you elect to pay out-of-pocket and submit a prescription claim directly to Health Net instead of having the contracted pharmacy submit the claim directly to Health Net, you will be

reimbursed based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription, less any applicable Copayment or Deductible.

Nonparticipating Pharmacies and Emergencies

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

If the above situations apply to you:

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

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

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

Except as specified in the "COVID-19 Outpatient Services" provision in this "Covered Services and Supplies" section, there are no benefits through Nonparticipating Pharmacies after 30 days of coverage or if the Prescription Drug was not purchased for Emergency Services and Care or Urgently Needed Care.

Note: The "Prescription Drug/Outpatient Prescription" portion of the "Exclusions and Limitations" section of this *Evidence of Coverage* and the requirements of the 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 of a Maintenance Drug, when appropriate; and
- The appropriate Copayment.

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

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

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

Note: Specialty Drugs and Schedule II narcotic drugs are not covered through our mail order program.

Chiropractic Services and Supplies

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

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

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any Contracted Chiropractor without a 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 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 may be subject to verification of medical necessity 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 a chiropractic manipulation (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 support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Second Opinion

If you would like a second opinion with regard to Covered Benefits 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" section.

Chiropractic Services and Supplies Exclusions and Limitations

The exclusions and limitations in the "Exclusions and Limitations" section also apply to Chiropractic Services.

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

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 Services or Investigational Services.

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Hypnotherapy

Hypnotherapy, behavior training, sleep therapy and weight programs are not 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 Musculoskeletal and Related Disorders are not covered. This means that physiotherapy 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.

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.

Vitamins

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

Acupuncture Services

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

Acupuncture Services are covered up to the maximum number of visits shown in the "Schedule of Benefits and Copayments" section.

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

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

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

All covered Acupuncture Services may be subject to verification of Medical Necessity by ASH Plans except:

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

The following benefits are provided for Acupuncture Services:

Office Visits

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

  Established patient exams are performed by a Contracted Acupuncturist to assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam must be Medically Necessary.
- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.

- Adjunctive therapy may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.

Only the treatment of Pain, Nausea or Musculoskeletal and Related Disorders is covered, provided that the condition may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice. Covered Pain and Musculoskeletal and Related Disorders include:

- Tension-type headache; migraine headache with or without aura;
- Hip or knee joint Pain associated with Osteoarthritis (OA);
- Other extremity joint Pain associated with OA or mechanical irritation/inflammation when chronic and unresponsive to standard medical care;
- Other Pain syndromes involving the joints and associated soft tissues;
- Musculoskeletal cervical spine, thoracic spine, and lumbar spine Pain.
- Covered Nausea includes:
- Nausea associated with pregnancy (only when co-managed);
- Post-operative Nausea/vomiting (generally within the first 24 hours after surgery) or post-discharge Nausea/vomiting (generally within a few days after post-operative discharge); (only when co-managed);
- Nausea associated with chemotherapy; (only when co-managed).

Second Opinion

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

Acupuncture Services Exclusions and Limitations

The exclusions and limitations in the "Exclusions and Limitations" section also apply to Acupuncture Services.

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

Services, laboratory tests, x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered.

If you have a Life-Threatening or Seriously Debilitating condition and ASH plans denies coverage based on the determination that the therapy is experimental, you may be able to request an Independent Medical Review of ASH Plans' determination. You should contact ASH Plans at 1-800-678-9133 for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Auxiliary Aids

Auxiliary aids and services are not covered. This includes but is not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

Diagnostic Radiology

No diagnostic radiology (including x-rays, magnetic resonance imaging or MRI) is covered.

Drugs

Prescription drugs and over-the-counter drugs are not covered.

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Acupuncture Services

Acupuncture care that is (a) investigatory; or (b) an unproven Acupuncture Service that does not meet generally accepted and professionally recognized standards of practice in the acupuncture provider community is not covered. ASH Plans will determine what will be considered Experimental Services or Investigational Services.

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Anesthesia

Charges for anesthesia are not covered.

Hypnotherapy

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

Noncontracted Providers

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

Acupuncture Services Not Listed under Acupuncture Services

Only Acupuncture Services that are listed under "Acupuncture Services" are covered. Unlisted services, which include, without limitation, services to treat asthma and services to treat any addiction, including treatment for smoking cessation, are not covered.

Out-of-State Services

Services provided by an acupuncturist practicing outside California are not covered, except with regard to Emergency Acupuncture Services.

Thermography

The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs

Transportation costs are not covered, including local ambulance charges.

X-ray and Laboratory Tests

X-ray and laboratory tests are not covered.

Medically/Clinically Unnecessary Services

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

Services Not Within License

Only services that are within the scope of licensure of a licensed acupuncturist in California are covered. Other services, including, without limitation, ear coning and Tui Na are not covered. Ear coning, also sometimes called "ear candling," involves the insertion of one end of a long, flammable cone ("ear cone") into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of Qi but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

Vitamins

Vitamins, minerals, nutritional supplements or other similar products are not covered.

EXCLUSIONS AND LIMITATIONS

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this *Evidence of Coverage* (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

Acupuncture Services

This Plan does not cover Acupuncture Services, except as described in this *EOC* in the "Schedule of Benefits and Copayments" section and the "Covered Services and Supplies" section or as required by law.

Chiropractic Services

This Plan does not cover Chiropractic Services, except as described in this *EOC* in the "Schedule of Benefits and Copayments" section and the "Covered Services and Supplies" section or as required by law.

Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, device or service itself;
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in this *EOC*, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this *EOC* in the "General Provisions" section or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this *EOC* in the "General Provision" section.

Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this *EOC* in the "Covered Services and Supplies" section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or

other treatment of hair loss or hair growth except as described in this *EOC* in the "Covered Services and Supplies" section, or as required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in the "Covered Services and Supplies" section.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by Physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in the "Covered Services and Supplies" section.

Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
- Custodial care provided in a healthcare facility.

Dental Services

This Plan does not cover dental services or supplies, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this *EOC* in the "Covered Services and Supplies" section under "Ostomy and Urological Supplies" or as required by law.

Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
3. Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan 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, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible Physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review

and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this *EOC* in the "General Provisions" section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the "General Provisions" section.

Vision Care

This Plan does not cover vision services, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Hearing Aids

This Plan does not cover hearing aids, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Nonlicensed or Noncertified Providers

This Plan does not cover treatments or services rendered by a nonlicensed or noncertified Health Care Provider, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

Prescription Drugs/Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
  - Insulin,
  - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
  - Over-the-counter drugs for reversal of an opioid overdose, or
  - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.

Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as described in this *EOC* in the "Surrogacy Arrangements" provision in the "General Provisions" section or as required by law.

Therapies

This Plan does not cover the following physical and occupational therapies, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under this *EOC* in the "Covered Services and Supplies" section or as required by law.

Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this *EOC* in the "Covered Services and Supplies" section, as otherwise described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

GENERAL PROVISIONS

When the Plan Ends

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

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

When the Plan Changes

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

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under the "Eligibility, Enrollment and Termination" section, "When Coverage Ends" regarding termination for nonpayment, Health Net will not provide notice of such changes to Plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to Plan Subscribers.

If you are confined in a Hospital when the Group Service Agreement is modified, benefits will continue as if the Plan had not been modified, until you are discharged from the Hospital.

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

Members' Rights, Responsibilities and Obligations Statement

Health Net is committed to treating Members in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, Health Net has adopted these Members' rights and responsibilities. These rights and responsibilities apply to Members' relationships with Health Net, its contracting practitioners and providers, and all other health care professionals providing care to its Members.

As a Members you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's Member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.

- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - Full and equal access, as other members of the public, to medical facilities.
  - Extra time for visits if you need it.
  - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.

- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - Your Plan or Health Care Provider.
  - Any care you receive, or access to care you seek.
  - Any covered service or benefit decision that your Plan makes.
  - Any improper charges or bills for care.
  - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.

- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

Appeal, complaint or grievance means any dissatisfaction expressed by you or your representative concerning a problem with Health Net, a medical provider or your coverage under this *EOC*, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination, as applicable to this group health plan, means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net Plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-888-893-1572** 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 chiropractic or acupuncture program, call the Health Net Customer Contact Center at **1-888-893-1572** or write to:

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

For grievances filed for reasons other than cancellation or nonrenewal of coverage, you must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. For grievances filed regarding cancellation or nonrenewal of coverage, you must file your grievance with Health Net within 180 days of the termination notice. Please include all information from your Health Net identification card and the details of the concern or problem.

We will:

- For grievances filed for reasons other than cancellation or nonrenewal of coverage, confirm in writing within five calendar days that we received your request. For grievances filed regarding cancellation, rescission or nonrenewal of coverage, confirm in writing within three calendar days that we received your request.
- For grievances filed for reasons other than cancellation or nonrenewal of coverage, review your complaint and inform you of our decision in writing within 30 days from the receipt of the grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the investigational or experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the Department of Managed Health Care for assistance or to request an Independent Medical Review, or you may initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an Independent Medical Review (IMR) of disputed Health Care Services from the Department of Managed Health Care (Department) if you believe that Health Care Services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any Health Care Service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in

support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

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

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

For nonurgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process, or to request an application form, please call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover experimental or investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is an Experimental or an 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 an Experimental Service or an Investigational Service, it would be covered.

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy.

For more information, please call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Health Net at **(1-800-522-0088)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech

impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Binding Arbitration

As a condition to becoming a Health Net Member, **YOU AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF YOUR HEALTH NET MEMBERSHIP TO FINAL BINDING ARBITRATION, EXCEPT AS THOSE DESCRIBED BELOW AND YOU AGREE NOT TO PURSUE ANY CLAIMS ON A CLASS ACTION BASIS. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes.** However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically, such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, Health Net uses binding bilateral arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, Health Care Providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000. In the event that total amount of damages is over $500,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

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

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

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician or the contracting Physician Group.
- Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.
- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.

- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the Health Care Provider, their office staff, the contracting Physician Group or Health Net personnel.
- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-Physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S., the treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org). Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

Health Net will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered Investigational Services or Experimental Services 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 Services or Experimental Services, 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 an Experimental Service or an Investigational Service, you may request an Independent Medical Review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

Health Net and the Health Care Providers that provide services to you through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all Covered Benefits that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

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

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

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

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

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

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

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

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

STEPS YOU MUST TAKE

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

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

How the Amount of Your Reimbursement is Determined

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

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

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

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

Surrogacy Arrangements

A Surrogacy Arrangement is an arrangement in which a 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 Benefits 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 Benefits that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if you provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to Health Net in advance of delivery, you will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

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

Duty to Cooperate

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

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

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

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

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

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

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals and other Health Care Providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital or other Health Care Provider.

All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of this Plan.

The Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees or of Physician Groups, any Physician or Hospital or any other person or organization with which Health Net has arranged or will arrange to provide the Covered Benefits of this Plan.

Provider/Patient Relationship

Member Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges

While it is not likely, it is possible that Health Net may be unable to pay a Health Net provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with Health Net. You may be held liable for the cost of services or supplies received from a noncontracting provider if Health Net does not pay that provider.

This provision does not affect your obligation to pay any required Copayment or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability

Health Net will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing or use of any Prescription Drug this Plan covers.

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to

ensure continuity of care. At least 60 days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other Hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the effective date of the contract termination.

In addition, a Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

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

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

Contracting Administrators

Health Net may designate or replace any contracting administrator that provides the Covered Benefits of this Plan. If Health Net designates or replaces any administrator and as a result procedures change, Health Net will inform you.

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this *Evidence of Coverage*.

Decision-Making Authority

Health Net has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Coordination of Benefits

The Member's coverage is subject to the same limitations, exclusions and other terms of this Evidence of Coverage whether Health Net is the Primary Plan or the Secondary Plan.

Coordination of Benefits (COB) is a process, regulated by law, that determines financial responsibility for payment of allowable expenses between two or more group health plans.

Allowable expenses are generally the cost or value of medical services that are covered by two or more group health plans, including two Health Net Plans.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health plan provides benefits in the form of services rather than cash payments.

Health Net's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between the two HMOs or insurers. However, you may occasionally be asked to provide information about your other coverage.

This Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determines 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 does not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions apply to the coverage provided under this Subsection only.

A. **"Plan"**—A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   1. **"Plan" includes** group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

      (Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits, please refer to "Government Coverage" portion of this "General Provisions" section).

   2. **"Plan" does not include** nongroup coverage of any type, amounts of Hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Each contract for coverage under (1) and (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan**—The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense**—This concept means a Health Care Service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

The following are examples of expenses or services that are **not Allowable Expenses**:

1. If a Member is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

   Exceptions:

   If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

5. The amount a benefit is reduced by the Primary Plan because of a Member does not comply with the plan provisions is not an Allowable Expense.

   Examples of these provisions are second surgical opinions, Prior Authorization of admissions and preferred provider arrangements.

D. **Claim Determination Period**—This is the Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

E. **Closed Panel Plan**—This is a Plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent**—This is a parent who has been awarded custody of a child by a court decree. In the absence of a court decree, it is the parent with whom the child resided more than half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among Health Net and other applicable group health Plans by establishing which Plan is primary, secondary and so on.

A. **Primary or Secondary Plan**—The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. **No COB Provision**—A Plan that does not contain a coordination of benefits provision is always primary.

   There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a closed Panel Plan to provide out-of-network benefits.

C. **Secondary Plan Performs COB**—A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. **Order of Payment Rules**—The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

   1. **Subscriber (Non-Dependent) vs. Dependent**—The Plan that covers the person other than as a dependent, for example as an employee, Subscriber or retiree, is primary and the Plan that covers the person as a dependent is secondary.

   2. **Child Covered By More Than One Plan**—The order of payment when a child is covered by more than one Plan is:

      a. **Birthday Rule**—The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

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

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

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

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

- The Plan of the Custodial Parent.
- The Plan of the spouse of the Custodial Parent.
- The Plan of the noncustodial parent.
- The Plan of the spouse of the noncustodial parent.

3. **Active vs. Inactive Employee**—The Plan that covers a person as an employee who is neither laid off nor retired (or their dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or their dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

   If the other plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D (1) above.

4. **COBRA Continuation Coverage**—If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage**—If the preceding rules do not determine the order or payment, the Plan that covers the Subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
   a. **Two Plans Treated as One**—To determine the length of time a person has been covered under a Plan; two Plans shall be treated as one if the Member was eligible under the second within twenty-four hours after the first ended.

   b. **New Plan Does Not Include**—The start of a new Plan does not include:
      i. A change in the amount or scope of a Plan's benefits.

      ii. A change in the entity that pays, provides or administers the Plan's benefits.

      iii. A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).

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

6. **Equal Sharing**—If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on the Benefits of This Plan

A. **Secondary Plan Reduces Benefits**—When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total Allowable Expenses.

B. **Coverage by Two Closed Panel Plans**—If a Member is enrolled in two or more closed panel plans and if, for any reason, including the person's having received services from a nonpanel provider, benefits are not covered by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

   But, if services received from a nonpanel provider are due to an emergency and would be covered by both plans, then both plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

Health Net may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Health Net need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give Health Net any facts it needs to apply those rules and determine benefits payable.

Health Net's Right to Pay Others

A "payment made" under another plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Government Coverage

Medicare Coordination of Benefits (COB)

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

If you are enrolled in Medicare Parts A and Part B, and are not an active employee or your employer group has less than twenty employees, then this Plan will coordinate with Medicare and be the secondary plan. This Plan also coordinates with Medicare if you are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If you are not enrolled in Medicare Part A and Part B, Health Net will provide coverage for Medically Necessary Covered Benefits without coordination with Medicare.) For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this Plan for the Covered Benefits described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net as required under this *Evidence of Coverage*.

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

For answers to questions regarding Medicare, contact:

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

Write to:

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

Medi-Cal

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

Veterans' Administration

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

Workers' Compensation

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

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

MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all Covered Benefits through a network of contracting Physician Groups. Your Physician Group performs or authorizes all care and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

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

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency Services and Care or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com to obtain claim forms.

If you need to file a claim for medical or Mental Health or Substance Use Disorder emergency services or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

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

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

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

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

If you need to file a claim for Emergency Chiropractic Services or Emergency Acupuncture Services or for other covered Chiropractic Services or covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with (ASH Plans) within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
Attention: Customer Contact Center
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Chiropractic Services or covered Acupuncture Services, you may call ASH Plans at **1-800-678-9133** or you may write ASH Plans at the address given immediately above.

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

Payment of Claim

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

Physician Self-Treatment

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

Treatment by Immediate Family Members

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

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

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

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

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. The *Evidence of Coverage*, however, will be posted electronically on Health Net's website at www.healthnet.com. The Group can opt for the Subscribers to receive the *Evidence of Coverage* online. By registering and logging on to Health Net's website, Subscribers can access, download and print the *Evidence of Coverage*, or can choose to receive it by U.S. mail, in which case Health Net will mail the *Evidence of Coverage* to each Subscriber's address on record.

If the Subscriber or the Group is required to provide notice, the notice should be mailed to the Health Net office at the address listed on the back cover of this *Evidence of Coverage*.

Transfer of Medical Records

A Health Care Provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY. **Effective 08.14.2017**

Covered Entities Duties:

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

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

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

- Uses or disclosures
- Your rights;
- Our legal duties; and
- Other privacy practices stated in the notice

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

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We are also committed in keeping your race, ethnicity, and language (REL),sexual orientation and gender identity (SOGI) and social needs information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.

This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities: *Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved Rev. 09/05/25*

- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

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

- ***Treatment*** - We may use or disclose your PHI to a Physician or other Health Care Provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the Health Care Services provided to you. We may disclose your PHI to another health plan, to a Health Care Provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity; and
  - performing utilization review of claims.
- ***Health Care Operations*** - We may use and disclose your PHI to perform our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment and for
  - 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; and
  - detecting or preventing health care fraud and abuse

  Your race, ethnicity, language, sexual, orientation, gender identity and social needs information are protected by the health plan's systems and laws. This means information you provide is private and

secure. We can only share this information with California regulatory agencies Health Care Providers, and health care oversight entities. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:

- better understand your healthcare needs;
- know your language preference when seeing healthcare providers;
- providing healthcare information to meet your care needs; and
- offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

- ***Group Health Plan/Plan Sponsor Disclosures*** - We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

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

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court;
  - Administrative tribunal;
  - Subpoena;
  - Summons;
  - Warrant;
  - Discovery request;
  - Similar legal request.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order;
  - Court-ordered warrant;
  - Subpoena;
  - Summons issued by a judicial officer, or
  - Grand jury subpoena.

  We may also disclose your relevant PHI 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; and
  - Tissues
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - To authorized federal officials for national security and intelligence activities
  - The Department of State for medical suitability determinations; and
  - For protective services of the President or other authorized persons
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

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

Impermissible Use of PHI – We will not use your language, race, ethnic background, sexual orientation, and gender identity and social needs information to deny coverage, services, benefits, or for underwriting purposes.

Individuals Rights

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

The state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net, LLC) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose Medical Information related to Sensitive Services provided to a Protected Individual to the Group, Subscriber, or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care. Refer to the customer service phone number on the back of your Member identification card or the plan's website for instructions on how to request confidential communication.
- ***Right to Access and Receive Copy of Your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend Your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

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

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our website or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-800-522-0088
Fax: 1-833-887-0151
Email: Privacy@healthnet.com

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer
c/o Office of Legal Services
California Department of Health Care Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Phone: **1-916-445-4646** or **1-866-866-0602** (TTY:TDD: 1-877-735-2929)
E-mail: Privacyofficer@dhcs.ca.gov

FINANCIAL INFORMATION PRIVACY NOTICE

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

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

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

- Information we receive from you on applications or other forms, such as name, address, age, Medical Information and Social Security number;

- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

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

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

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

Questions about this Notice:

If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

Health Net, LLC
Attn: Privacy Official
21281 Burbank Blvd
Woodland Hills, CA 91367

Please **call the toll-free phone number on the back of your ID card** or contact Health Net at **1-888-893-1572**.

DEFINITIONS

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

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Musculoskeletal and Related Disorders, Nausea and Pain. Acupuncture Services include services rendered by an acupuncturist for the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. Acupuncture Services do not include any other services, including, without limitation, services for treatment of asthma or addiction (including, but not limited to, smoking cessation).

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Benefits shall be provided for the duration of the Acute Condition.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

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 and Acupuncture Services through a network of Contracted Chiropractors and Contracted Acupuncturist.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  - The United States Department of Veterans Affairs.
  - The United States Department of Defense.
  - The United States Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Health Net.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Chiropractic Appliances are support type devices prescribed by a Contracted Chiropractor specifically for the treatment of a Musculoskeletal and Related Disorder. The devices this 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, and 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 Musculoskeletal and Related Disorders and Pain syndromes. These services are limited to the management of Musculoskeletal and Related 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.

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered Acupuncture Services to Members.

Contracted 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.

Copayment is a fee charged to you for Covered Benefits when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each covered service is shown in the "Schedule of Benefits and Copayments" section.

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

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this *Evidence of Coverage* or under California health plan law.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of nonemergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

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

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

Domestic Partner is, for the purposes of this *Evidence of Coverage*, the Subscriber's partner if the Subscriber and partner are a couple who are registered domestic partners that meet all the requirements of Sections 297 or 299.2 of the California Family Code.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or coinsurance or your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum.)

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).

- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the Plan.

Emergency Acupuncture Services are Covered Benefits that are Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system, or causing Pain or Nausea which manifests itself by acute symptoms or sufficient severity such that a person could reasonably expect that a delay of immediate Acupuncture 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 Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

Emergency Chiropractic Services are Covered Benefits 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' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's independent medical review process.

Emergency Medical Condition means 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; or.
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a Physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a Physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical 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 within the capability of the facility.

Evidence of Coverage (EOC) means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is 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 and Acupuncture Services, "Experimental" services are chiropractic care or acupuncture care that is an unproven Chiropractic Service or Acupuncture Service that does not meet professionally recognized, valid, evidence-based standards of practice.

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

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

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 Formulary is also referred to as "Recommended Drug List." Some drugs in the Formulary require Prior Authorization from Health Net in order to be covered.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a Health Care Provider by the state of California to perform the services, acting within the scope of their license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net 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 Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in their place of residence that is prescribed by the Member's attending Physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are Covered Benefits under this Plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to 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. Your Plan must pay for the services if an IMR decides you need it.

Infertility exists when any of the following apply to a Member when the Member or the Member's partner has not yet gone through menopause:

- The Member has had 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
- A licensed Physician's determination of infertility, based on the Member's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

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 Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and

3. The service is not in wide usage.

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.

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

Maximum Allowable Cost for any Prescription Drug is the maximum charge Health Net will allow for Generic Drugs or Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Cost is maintained and may be revised periodically by Health Net.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating Physician, or other Health Care Provider.

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

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Musculoskeletal and Related 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.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change Physician Groups at this time.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted or on any date approved by Health Net.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments and Deductibles you must pay for Covered Benefits for each Calendar Year. Deductibles and Copayments, which are paid toward certain Covered Benefits are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in the "Out-of-Pocket Maximum" section.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic

according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain, and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net, to provide Mental Health or Substance Use Disorder benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Substance Use Disorder rehabilitation services.

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health and Substance Use Disorder rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this 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.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

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

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Prescription Drug Order is a written or verbal order, or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

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

Benefits" section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health
- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician is a Member Physician who coordinates and controls the delivery of Covered Benefits 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.

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 noninstitutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Protected Individual means any adult covered by the Subscriber's health care service plan or a minor who can consent to a Health Care Service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A health care service plan shall not require a Protected Individual to obtain the Group, Subscriber, or other Member authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the Protected Individual has the right to consent to care.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or 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:
  A. Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;

  B. Is supervised by a Qualified Autism Service Provider;

  C. Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (

  D. Is either of the following:
     i. Is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; or

     ii. A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology;

  E. Is either of the following:
     i. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; or

     ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional; and

  F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to

improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a Telehealth Service provider that is contracted with Health Net to provide Telehealth Services that are covered under the "Telehealth Consultations through the Select Telehealth Services Provider" heading as shown in the "Schedule of Benefits and Copayments" and "Covered Benefits" sections. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Sensitive Services means all Health Care Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929, 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

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

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this

Evidence of Coverage. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of their family who meet the eligibility requirements of the Group and Health Net.

Substance Use Disorder Care Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is licensed to provide Substance Use Disorder detoxification services or rehabilitation services.

Telehealth Services means the mode of delivering Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

For the purposes of this definition, the following apply:

- "Asynchronous store and forward" means the transmission of a patient's Medical Information from an originating site to the Health Care Provider for telehealth at a distant site without the presence of the patient.
- "Distant site" means a site where a Health Care Provider for telehealth who provides Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Health Care Services are provided via telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a Health Care Provider for telehealth located at a distant site.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Benefits shall be provided for the duration of a Terminal Illness.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

Urgently Needed Care includes an otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of their health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

LANGUAGE ASSISTANCE SERVICES

Health Net provides free language assistance services, such as, in-person interpretation, telephone interpretation, video remote interpretation, sign language interpretation, translated written materials oral translation and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual multilingual staff and interpreter services for additional languages to support Member language needs. Interpretation services in your language can be used for, but not limited to, explaining benefits, filing a grievance and answering questions related to your health Plan. Also, our Customer Contact Center staff can help you find a Health Care Provider who speaks your language. Call the Customer Contact Center number on your Health Net ID card for this free service and to schedule an interpreter. Providers may not request that you bring your own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a Covered Benefit or service is accessed. If you cannot locate a Health Care Provider who meets your language needs, you can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for Health Care Services in such a manner that ensures the provision of interpreter services at the time of the appointment. Some types of interpretation must be scheduled before the appointment.

NOTICE OF LANGUAGE SERVICES

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Համախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange: 1-800-839-2172（TTY: 711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY: 711）または Small Business 1-888-926-5133（TTY: 711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY: 711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bąąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shich[' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíį[' hodíilnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonlhį[' bikáá' éí doodago koj[' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí koj[' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí koj[' hólne' -888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí koj[' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (Off Exchange (IFP به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੋਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੇਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

NONDISCRIMINATION NOTICE

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Health Net Customer Contact Center at
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-888-893-1572 (TTY: 711)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Customer Contact Center 1-800-675-6110 (TTY: 711)
California Relay 711

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

- Electronically: Send an email to SM_Section1557Coord@centene.com
  This notice is available at Health Net website:
  https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html

If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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Contact us

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

Customer Contact Center
Large Group:
1-888-893-1572 TTY: 711
(for companies with 101 or more employees)

Small Group:
1-888-893-1572 TTY: 711
(for companies with 1-100 employees)

Individual & Family Plans:
1-800-839-2172 TTY: 711

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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