Evidence of Coverage and Plan Document

A complete explanation of your Plan

OOS PPO (Plan NB1)

Important benefit information – please read

Dear Health Net Member:

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

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

If your Group has requested that we make it available, you can choose to access this document online through Health Net's secure website at www.healthnet.com/psbp. 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/psbp 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at **1-888-893-1572**. 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 pays Participating Providers on a fee-for-service basis, according to an agreed Contracted Rate. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Health Net ID card.

Use of Special Words

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

In addition, the following words are used frequently:

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

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INTRODUCTION TO HEALTH NET

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

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

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

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

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

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

How to Obtain Care – In-Network

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

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

To obtain a copy of the *Health Net PPO Network Directory*, please contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at

www.healthnet.com/psbp. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more.

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

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

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

Preferred Providers may refer Members to Out-of-Network Providers. If you receive care from an Out-of-Network Provider, even if the referral to that provider is from a Preferred Provider, then services are covered at the out-of-network benefit level. It is your obligation to confirm if the provider, to whom you are referred, is a Preferred Provider or an Out-of-Network Provider. To verify if the provider is a Preferred Provider, check the *Health Net PPO Network Directory*, contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com/psbp. You are responsible for the cost share of the benefit level (that is, Preferred Provider or Out-of-Network Provider) that applies to the provider.

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

Specialists and Referral Care

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

Covered Services that are not Available through a Preferred Provider

Health Net may authorize covered services from an out-of-network Specialist or ancillary provider when the Member cannot obtain Medically Necessary care from a Preferred Provider because either: (1) Health Net does not have the provider type in its network; or (2) Health Net does not contract with the provider type within a reasonable distance from the Member's residence and an Out-of-Network Provider of that type is within such reasonable distance. When Health Net authorizes such care, covered services from the Out-of-Network Provider will be paid at the in-network level of benefit. The Member will pay the cost sharing as shown under the "Preferred Provider" tier in the "Schedule of Benefits" section of this *EOC*.

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

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

How to Obtain Care – Out-of-Network

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

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

Specialists and Referral Care

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

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

Your Financial Responsibility

Preferred Providers

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

Out-of-Network Providers

Covered services or supplies from Out-of-Network Providers are paid at the out-of-network benefit level. Your share of cost is based on the Maximum Allowable Amount. For more information on how we determine the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Evidence of Coverage*. You are responsible for any applicable

Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of the Maximum Allowable Amount. THEREFORE, WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.

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

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

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

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

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

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

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

Deductible

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

Nonauthorization Penalties

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

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

Questions

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

Timely Access to Care – Preferred Providers

The California Department of Managed Health Care (DMHC) has issued regulations (California Code of Regulations, Title 28, Section 1300.67.2.2) with requirements for timely access to nonemergency Health Care Services. Health Net's in-network providers agree to provide timely access to care.

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with an In-Network Physician

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

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Urgent care appointment with non-Physician behavioral health care provider or behavioral health care physician (psychiatrist) that does not require Prior Authorization:** within 48 hours of request
- **Urgent care appointment with non-Physician behavioral health care provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization:** within 96 hours of request
- **Nonurgent appointment with behavioral health care Physician (psychiatrist):** within 15 business days of request
- **Nonurgent appointment with non-Physician behavioral health care provider:** within 10 business days of request
- **Nonurgent follow-up appointment with non-Physician mental health care provider (NPMH):** within 10 business days of request
- **Non-life-threatening behavioral health emergency:** within 6 hours of request for an appointment

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

Scheduling Appointments with an In-Network Specialist for Medical and Surgical Services

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

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

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

Scheduling Appointments for In-Network Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

As a Health Net Member, you have access to triage or screening 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.

Transition of Care for New Enrollees

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

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from your Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal Mental Health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

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

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

Emergency and Urgently Needed Care through Your PPO Plan

WHAT TO DO WHEN YOU NEED MEDICAL OR MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE IMMEDIATELY

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

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

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

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

Urgently Needed Care is covered and does not require Prior Authorization. Urgently Needed Care is covered at the benefit level that applies to the provider of service. Always present your Health Net PPO ID card to the health care provider regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician.

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

Follow-Up Care *services performed by an Out-of-Network Provider are covered as described earlier in this section under "How to Obtain Care – Out-of-Network."*

Follow-Up Care after Emergency Care at a Hospital*: If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the Hospital must contact Health Net to obtain timely Prior Authorization or you will be subject to the nonauthorization penalty. If you want to be transferred from an Out-of-Network Hospital to a Preferred Provider Hospital, and Health Net determines that you may be safely transferred, Health Net will arrange for the transfer and for the care to continue at the Preferred Provider Hospital*

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

Prescription Drugs

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

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

Note(s):

The "Prescription Drugs" portion of the "Exclusions and Limitations" section and the requirements of the Formulary also apply.

SCHEDULE OF BENEFITS

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

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

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

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

Covered services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as covered services delivered in-person. Telehealth Services will be covered only when performed by a Preferred Provider. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

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

Calendar Year Deductible

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

	Preferred Provider	Out-of-Network Provider
Calendar Year Deductible, per Member	Not applicable	$200
Calendar Year Deductible, per family	Not applicable	$600

Note(s):

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

- Only Covered Expenses for services or supplies received through an Out-of-Network Provider will be applied to the satisfaction of the Calendar Year Deductible. The following does not apply to the Calendar Year Deductible:
  - Any nonauthorization penalties incurred by you for receiving nonauthorized services,
  - Expenses incurred under the Prescription Drug benefit.

Nonauthorization Penalties

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

	Preferred Provider	Out-of-Network Provider
Medically Necessary services for which Prior Authorization was required but not obtained	50%	50%

Note(s):

- **Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply.**
- **The nonauthorization penalty listed above will apply before the Coinsurance is reduced to the amount shown. The nonauthorization penalty will not exceed the cost of the benefit to Health Net.**
- You will be responsible for an additional amount of Coinsurance based on the amount of the nonauthorization penalty.
- For a list of services which require Prior Authorization, please see the "Prior Authorization Requirement" section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

Copayments and Coinsurance (Including any Additional Benefit Deductibles)

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

When a covered service or supply is subject to a Copayment and a Coinsurance, the Copayment will apply first, then the Coinsurance percentage payable by the Member will be calculated from the Covered Expense amount less the Copayment amount.

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Emergency room (facility and professional services)	20%	20% (Deductible waived)
Urgent care center (facility and professional services)	20%	20% (Deductible waived)

Note(s):

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

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Emergency room (facility and professional services)	20%	20% (Deductible waived)
Urgent care center (facility and professional services)	$0	20% (Deductible waived)

Note(s):

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

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider
Ground ambulance	20%	20% (Deductible waived)
Air ambulance	20%	20% (Deductible waived)

Note(s):

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

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

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

Ambulance Services (Mental Health and Substance Use Disorder services)

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Ground ambulance	20%	20% (Deductible waived)
Air ambulance	20%	20% (Deductible waived)

Note(s):

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

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

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

Office Visits

	Preferred Provider	Out-of-Network Provider
Visit to Physician, Physician Assistant or Nurse Practitioner	$20	40%
Specialist consultation	$20	40%
Physician visit to Member's home	20%	40%
Specialist visit to Member's home	20%	40%
Annual nonpreventive routine physical examination (age 17 and older)*	$20	40%
Combined Calendar Year maximum payable by Health Net	*$250*	*$250*
Vision examination (for diagnosis or treatment, including refractive eye examinations) by an ophthalmologist (birth through age 16)	$20	40%
Vision examination (for diagnosis or treatment, including refractive eye examinations) by all other providers including optometrists (birth through age 16)	$20	40%

Hearing examination for hearing loss by an otolaryngologist (birth through age 16)	$20	40%
Hearing examination for hearing loss by all other providers including audiologists (birth through age 16)	$20	40%
Telehealth consultation through the Select Telehealth Services Provider**	$0	Not Covered

Note(s):

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

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

Preventive Care Services

	Preferred Provider	Out-of-Network Provider
Preventive Care Services	$0	40%

Note(s):

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

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

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

Hospital Visits by Physician

	Preferred Provider	Out-of-Network Provider
Physician visit to Hospital or Skilled Nursing Facility	20%	40%

Note(s):

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

Allergy, Immunizations and Injections

	Preferred Provider	Out-of-Network Provider
Allergy testing	$20	40%
Allergy injection services (serum not included)	$20	40%
Allergy serum	20%	40%
Injections (Office-based medications – administration (per dose)	$20	40%
Office-based injectable* medications - injected substance (per dose) *	$20	40%

Note(s):

- Immunizations that are part of Preventive Care Services are covered under "Preventive Care Services" in this section.
- Injections for the treatment of Infertility are described below in the "Infertility Services" section.

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

Rehabilitation and Habilitation Therapy

	Preferred Provider	Out-of-Network Provider
Physical therapy, speech therapy, occupational therapy, habilitation therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	20%	40%
Combined visits per Calendar Year	*20*	*20*

Note(s):

- These services will be covered when Medically Necessary.
- Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation and Habilitation Therapy" portion of the "Exclusions and Limitations" section.
- Benefits for up to 12 additional visits for physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy may be covered if Prior Authorized as Medically Necessary for rehabilitation services following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma and spinal cord injury. All visit maximums will be combined for covered services and supplies provided by Preferred Providers and Out-of-Network Providers. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations. In addition, Medically Necessary rehabilitative or habilitative services for autism or pervasive developmental disorder are not subject to such visit limitations.

  The coverage described above in the preceding paragraph, in relation to Medically Necessary rehabilitative services for post-mastectomy lymphedema syndrome, complies with requirements under the ***Women's Health and Cancer Rights Act of 1998***. In compliance with the ***Women's Health 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.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this section if Prior Authorization is required but not obtained.

Care for Conditions of Pregnancy

	Preferred Provider	Out-of-Network Provider
Prenatal office visit	$0	40%
Postnatal office visit	20%	40%
Specialist consultation regarding pregnancy	$20	40%

Newborn care office visit (birth through 30 days)	$20	40%
Physician visit to the mother or newborn at a Hospital	20%	40%
Normal delivery, including cesarean section, prenatal and postnatal care (other than office visits)	20%	40%
Circumcision of newborn (birth through 30 days)*	20%	40%

Note(s):

- The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance that may apply. Genetic testing is covered as a laboratory service as shown under the "Other Professional Services" heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.
- Termination of pregnancy and related services are covered in full. Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full under Preferred Providers and the Calendar Year Deductible does not apply. See "Preventive Care Services" above. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" in the "Covered Services and Supplies" section.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

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

Family Planning

	Preferred Provider	Out-of-Network Provider
Sterilization of female	$0	40%
Sterilization of male	$0	40%

Note(s):

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

- The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance that may apply.
- Sterilization of females and contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

Infertility Services

	Preferred Provider	Out-of-Network Provider
Infertility services (all services that diagnose, evaluate or treat infertility)	See note below*	See note below*

Note(s):

- Infertility services (which include GIFT, IVF and ZIFT (limited to 3 completed oocyte retrieval cycles per lifetime) and all covered services 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.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

Other Professional Services

	Preferred Provider	Out-of-Network Provider
Surgery or assistance at surgery Performed in an office or outpatient facility	20%	40%
Surgery or assistance at surgery Performed in an inpatient setting	20%	40%
Administration of anesthetics Performed in an office or outpatient facility	20%	40%

Administration of anesthetics Performed in an inpatient setting	20%	40%
Chemotherapy	20%	40%
Radiation therapy Performed in an outpatient setting	20%	40%
Radiation therapy Performed in an inpatient setting	20%	40%
Laboratory services in a Physician's office or outpatient facility	20%	40%
Laboratory services in an inpatient setting	20%	40%
Diagnostic imaging (including x-ray) services in a Physician's office or outpatient facility	20%	40%
Diagnostic imaging (including x-ray) services in an inpatient setting	20%	40%
Complex radiology (CT, SPECT, MRI, MUGA and PET)	20%	40%
Medical social services	20%	40%
Patient education*	$0	40%
Nuclear medicine (use of radioactive materials) Performed in an outpatient setting	20%	40%
Nuclear medicine (use of radioactive materials) Performed in an inpatient setting	20%	40%
Renal dialysis	20%	40%
Organ, tissue or stem cell transplants	See note below**	Not Covered
Infusion therapy In an office or outpatient setting	20%	40%
Infusion therapy In a home setting	20%	40%

Note(s):

- The above Copayments or Coinsurance apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance that may apply.
- Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

* Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care through Preferred Providers 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 or Coinsurance will apply.

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

Medical Supplies

	Preferred Provider	Out-of-Network Provider
Durable Medical Equipment, nebulizers, including face masks and tubing*	20%	40%
Orthotics (such as bracing, supports and casts)	20%	40%
Diabetic equipment, including diabetic footwear**	20%	40%
Corrective Footwear (for treatment of conditions not related to diabetes)	20%	40%
Prostheses (internal or external)***	20%	40%
Blood or blood products except for drugs used to treat hemophilia, including blood factors	20%	40%
Drugs used to treat hemophilia, including blood factors****	$20 (Deductible waived)	$20

Note(s):

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section. For additional information, please refer to the "Preventive Care Services" provision in this "Covered Services and Supplies" section.
- If the retail charge for the medical supply is less than the applicable Copayment, you will only pay the retail charge.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

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

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

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

****Drugs for the treatment of hemophilia, including blood factors, are also covered under the Prescription Drug benefit.

Home Health Care Services

	Preferred Provider	Out-of-Network Provider
Home health visit	20%	40%

Note(s):

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

Hospice Services

	Preferred Provider	Out-of-Network Provider
Hospice care	20%	40%

Note(s):

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

Acupuncture and Chiropractic Services

	Preferred Provider	Out-of-Network Provider
Acupuncture Deductible (applies each Calendar Year Combined with chiropractic services Deductible	$200	$200
Acupuncture	20%	40%
Combined Calendar Year maximum	*15 visits*	*15 visits*
Chiropractic Deductible (applies each Calendar Year Combined with chiropractic services Deductible	$200	$200
Chiropractic services	20%	40%
Combined Calendar Year maximum	*15 visits*	*15 visits*

Note(s):

- Covered chiropractic appliances are covered in full to a Calendar Year maximum of $50.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.
- Up to 15 Medically Necessary office visits to a Contracted Chiropractor during a Calendar Year are covered (combined with office visits to the Contracted Acupuncturist).

Inpatient Hospital Services

	Preferred Provider	Out-of-Network Provider
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services	$250 plus 20%	$250 plus 40%

Note(s):

- The above cost-sharing amounts apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments or Coinsurance. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments or Coinsurance that may apply.
- Inpatient care for Infertility is described above in the "Infertility Services" section.

- The above cost-sharing amounts apply to the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Deductible and 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.
- The Preferred Provider Coinsurance will apply if you are admitted to a Hospital directly from an emergency room or urgent care center. You will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.
- Services for organ, tissue and stem cell transplants by Out-of-Network Providers are not covered.

Outpatient Facility Services

	Preferred Provider	Out-of-Network Provider
Outpatient surgery (Hospital charges only, except for Infertility services)	$0	40%
Outpatient surgery (Outpatient Surgical Center charges only, except for Infertility services)	$0	40%
Outpatient services (other than surgery, except for Infertility services)	$0	40%

Note(s):

- Outpatient care for Infertility is described above in the "Infertility Services" section.
- The above cost-sharing amounts apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments or Coinsurance. Look under the "Care for Conditions of Pregnancy", "Family Planning" and "Other Professional Services" headings to determine any additional Copayments or Coinsurance that may apply.
- Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services or physical therapy are subject to the same Copayment or Coinsurance that is required when these services are performed at your Physician's office. Look under the headings for the various services such as office visits, rehabilitation and other professional services to determine any additional Copayment or Coinsurance payments that may apply.

- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

Skilled Nursing Facility Services

	Preferred Provider	Out-of-Network Provider
Room and board in a semi-private room with ancillary (additional) services	$250 plus 20%	$250 plus 40%

Note(s):

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

Mental Health and Substance Use Disorders

Mental Health	Preferred Provider	Out-of-Network Provider
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	$0	$0 (Deductible waived)

Outpatient services other than office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$0	$0 (Deductible waived)
Mental health professional visit to Members home (at the discretion of the mental health professional)	$0	$0 (Deductible waived)
Mental health professional visit to Hospital, behavioral health facility or Residential Treatment Center	20%	20% (Deductible waived)
Inpatient services at a Hospital, behavioral health facility or Residential Treatment Center	20%	20% (Deductible waived)
Substance Use Disorder	**Preferred Provider**	**Out-of-Network Provider**
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	$0	$0 (Deductible waived)

Outpatient services other than office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, day treatment and partial hospitalization)	$0	$0 (Deductible waived)
Mental health professional visit to Members home (at the discretion of the mental health professional)	$0	$0 (Deductible waived)
Mental health professional visit to Hospital, behavioral health facility or Residential Treatment Center	20%	20% (Deductible waived)
Inpatient services at a Hospital, behavioral health facility or Residential Treatment Center	20%	20% (Deductible waived)
Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center	20%	20% (Deductible waived)

Note(s):

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.
- Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section for details. Payment of benefits will be reduced as set forth under "Nonauthorization Penalties" in this "Schedule of Benefits" section if Prior Authorization is required but not obtained.

Prescription Drugs

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

For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portions of the "Covered Services and Supplies" and the "Exclusions and Limitations" sections.

Copayment and Coinsurance

Retail Pharmacy (up to a 30-day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	$10	$10 plus 50%
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	$25	$25 plus 50%
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	$55 plus 50%
Infertility drugs (including injectable drugs)	See note below*	See note below*
Weight loss drugs for the treatment of obesity (including injectable drugs)	50%	50%
Preventive drugs and contraceptives	$0	$0

Specialty Drugs (up to a 30 day supply)	**Specialty Pharmacy Vendor**

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.....$20

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

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.....$50

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

Preventive drugs and contraceptives.....$0

Note(s):

- **You will be charged the Copayment or Coinsurance for each Prescription Drug Order. The Coinsurance listed above is based on the Prescription Drug Covered Expense.**
- **Prescription Drugs will have a Copayment and Coinsurance maximum of $250 for an individual prescription of up to a 30-day supply**
- Percentage Copayments will be based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription for covered Prescription Drugs.
- *Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of $200 for an individual prescription of up to a 30-day supply and $600 for an individual prescription of up to a 90-day supply.*
- *If the pharmacy's cost of the prescription is less than the applicable Copayment or Coinsurance, you will pay the pharmacy's cost of the prescription and it will accrue to the Deductible and Out-of-Pocket Maximum.*
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net at the Copayment or Coinsurance for Tier 3 Drugs. Covered Brand Name Drugs are subject to the applicable Prescription Drug Deductible and Copayment or Coinsurance for Tier 2 Drugs or Tier 3 Drugs.

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

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

Prior Authorization:

- Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Services and Supplies" for a description of Prior Authorization requirements or visit our website at www.healthnet.com/psbp 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.

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.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.

Mail Order:

- Up to a 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.
- Maintenance Drugs on the Health Net Maintenance Drug List may also be obtained at a CVS retail pharmacy under the mail order program benefits.

Diabetic Supplies:

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

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

Specialty Drugs:

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

OUT-OF-POCKET MAXIMUM

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

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

The OOPM amounts for the medical benefits are:

	Preferred Provider	Out-of-Network Provider
Individual OOPM	$1500	$1500
Family OOPM	$4500	$4500

The OOPM amounts for the Prescription Drug benefits are:

	Participating Pharmacy	Non Participating Pharmacy
Individual OOPM	$2000	$2000
Family OOPM	$4000	$4000

Exceptions to OOPM

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

- 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.

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

Note(s):

All Specialty Drugs will be applied to the Pharmacy OOPM.

How the OOPM Works

- Any Deductible, Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductible, Copayments or Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for out-of-network Emergency Care (including emergency medical transportation, emergency Hospital care) and urgent care received outside the United States will be applied to the Out-of-Pocket Maximum for Preferred Providers.

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

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

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who is Eligible for Coverage

The Covered benefits of this Plan are available to eligible employees (Subscribers) of a Group that is based in the Service Area, as long as they live in the continental United States; 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 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.

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

Eligible employees who enroll in this Plan are called Subscribers.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse (and your spouse's eligible children) within 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.

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

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

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

Legal Ward (Guardianship): If the Subscriber or spouse becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 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 Health Net's Customer Contact Center upon your Effective Date about the confinement.

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

Totally Disabled on Your Effective Date

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

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

Late Enrollment Rule

Health Net's late enrollment rule requires that if an individual does not enroll within 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 Group should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

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

Exceptions to Late Enrollment Rule

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

1. **You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced**
   If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you if:
   - You never received from your Group or signed a form explaining the consequences of your decision; or
   - The signed form exists but cannot be produced as evidence of your informed decision.
2. **You 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 Group stops making contributions toward employee's or dependent's coverage.
   - When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual.
   - The other Subscriber or employee dies.
   - The Subscriber and spouse are divorced or legally separated and this causes loss of the other group coverage.
   - Loss of coverage because of cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan).
   - The other coverage was federal COBRA or California COBRA and the period of coverage ends.

3. **You 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 childbirth, marriage, adoption or placement for adoption.

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

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

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

The Effective Date of coverage for you and all family members who enroll within 30 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth.
- For marriage or domestic partnership, the Effective Date will be the first of the month following the date 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.

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

While you have 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.

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

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

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

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

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

- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to the Subscriber only because of the marriage, will end.
- When the Member ceases to reside in the continental United States, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred.

For any termination for loss of eligibility, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice; (c) your right to

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

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

Termination for Cause

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

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

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

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

How to Appeal Your Termination

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

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

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the “Grievance Procedures” provision in the

"General Provisions" section. If your complaint is decided in your favor, Health Net will reinstate your coverage back to the date of the termination.

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

Coverage Options Following Termination

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

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

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

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

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

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

  The Member must submit the first payment within 45 days of delivering the completed enrollment form to Health Net in accordance with the terms and conditions of the health Plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Member's first payment

must be delivered to Health Net by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to Health Net, the Member's Cal-COBRA election is not effective and no coverage is provided.

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

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

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

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

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

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

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

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

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

- **USERRA Coverage**: Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from 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 Deductible, Copayments and Coinsurance payments shown in the "Schedule of Benefits" section will continue to apply.

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

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

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

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

How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician that the Member is totally disabled.

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

When the Extension Ends

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

- On the date the Member is no longer totally disabled;
- 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;
- On the date that available benefits are exhausted; or
- On the last day of the 12-month period following the date the extension began.

PRIOR AUTHORIZATION REQUIREMENT

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

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

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

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

Prior Authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your Plan. Even if a service or supply is authorized, eligibility rules and benefit limitations will still apply. However, Health Net will not rescind or modify Prior Authorization after a provider renders Health Care Services in good faith and pursuant to the Prior Authorization, and will pay benefits under the *Evidence of Coverage* for the services authorized.

Services Requiring Prior Authorization

Inpatient admissions

Any type of facility, including but not limited to:

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

Outpatient procedures, services or equipment

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

- Bronchial thermoplasty
- Capsule endoscopy
- Cardiovascular procedures
- Chiropractic care (after the initial consultation)
- Clinical trials
- Diagnostic procedures including:
  1. Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
  2. Cardiac imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Myocardial Perfusion Imaging (MPI)
     - Multigated Acquisition (MUGA) scan
  3. Sleep studies
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Epidural spine injections and single injection trials for intrathecal pumps
- Experimental or Investigational services and new technologies.
- Facet joint denervation, injection or blocks
- Gender affirming services
- Genetic testing (Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer)
- Implantable Pain pumps including insertion or removal
- Injection, including trigger point, and sacroiliac (SI) joint injections
- Joint surgeries
- Mental Health and Substance Use Disorder services other than office visits including:
  1. Applied Behavioral Analysis (ABA) and other forms of Behavioral Health Treatment (BHT) for autism and pervasive developmental disorders
  2. Electroconvulsive Therapy (ECT)
  3. Half-day partial hospitalization

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

- Neuro or spinal cord stimulator
- Neuropsychological testing
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made)
- Pharmaceuticals
  1. Outpatient Prescription Drugs
     - Most Specialty Drugs, including self-injectable drugs and hemophilia factors, must have Prior Authorization through the "Outpatient Prescription Drugs" benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Formulary to identify which drugs require Prior Authorization. Urgent or emergent drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.
     - Other Prescription Drugs, as indicated in the Formulary, may require Prior Authorization. Refer to the Formulary to identify which Drugs require Prior Authorization.
  2. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, freestanding infusion center, home infusion, Outpatient Surgical Center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net website, www.healthnet.com/psbp, for a list of Physician-administered drugs that require Prior Authorization. Biosimilars are required in lieu of branded drugs, unless Medically Necessary.
- Proprietary laboratory analysis
- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  1. Bone alteration or reshaping such as osteoplasty
  2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
  3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
  4. Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection or implants

5. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
8. Hair electrolysis, transplantation or laser removal
9. Lift such as arm, body, face, neck, thigh
10. Liposuction
11. Nasal surgery such as rhinoplasty or septoplasty
12. Otoplasty
13. Penile implant
14. Treatment of varicose veins
15. Vermilionectomy with mucosal advancement

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

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

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

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

Exceptions

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

- Prior Authorization is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, please notify Health Net within 24 hours following birth or as soon as reasonably possible. Prior Authorization must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.
- Prior Authorization is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy).
- Other than Prescription Drugs, services provided pursuant to a CARE agreement or CARE plan approved by a court do not require Prior Authorization. See "Treatment Related to Judicial or Administrative Proceedings" in the "Exclusions and Limitations" section for more information.
- Prior Authorization by Health Net may be required for certain drugs. Please refer to "Prior Authorization and Step Therapy Exception Process for Prescription Drugs" in the "Prescription Drugs" section. You may refer to our website at www.healthnet.com/psbp to review the drugs that require a Prior Authorization as noted in the Formulary.

Prior Authorization Procedure

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

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

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

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

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

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

Effect on Benefits

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

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

Resolution of Disputes

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

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

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

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

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

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

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

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

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

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

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

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

- ***Maximum Allowable Amount for Out-of-Network Emergency Care*** will be the greatest of: (1) the median of the amounts negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method Health Net generally uses to determine payments for Out-of-Network providers, excluding any in-network Deductible, Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance. Emergency Care from an Out-of-Network Provider is subject to the applicable Deductible, Copayment and/or Coinsurance at the Preferred Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Care.
- ***Maximum Allowable Amount for nonemergent services at an in-network health facility***, at which, or as a result of which, you receive nonemergent covered services by an Out-of-Network Provider, the nonemergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

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

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

be responsible for any applicable Deductible, Copayment and/or Coinsurance at the out-of-network benefit level.

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

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

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

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.

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

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

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

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).

Certain limitations may apply.

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

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

Office Visits

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

Preventive Care Services

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

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

- U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations)
- 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)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (http://www.cdc.gov/vaccines/schedules/index.html)
- Guidelines for 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 screenings
- 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 and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), breast cancer screening (mammograms, including three-dimensional (3D) mammography, also known as digital breast tomosynthesis), lung cancer, cervical and colorectal cancer screening (e.g., colonoscopies)
- Human Immunodeficiency Virus (HIV) testing and screenings;
- 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 domestic violence screening and counseling.

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

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

COVID-19 Outpatient Services

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

- Covered in full when provided by a Participating Pharmacy or through a Preferred Provider; or
- Covered at the applicable Member cost share when provided by a Nonparticipating Pharmacy or Out-of-Network Provider.

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

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

Surgical Services

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

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

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

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

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

Gender Affirming Surgery

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

Reasonable travel, lodging and meal costs, as determined by Health Net, for a Member to undergo an authorized gender affirming surgery are covered limited to a lifetime maximum of $75,000. Travel and lodging are only available for the patient (companion not covered).

If you live 50 miles or more from the nearest authorized gender affirming surgery facility, 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 gender affirming 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 gender affirming surgery facility 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).
- 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.
- 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.
- Certain services require Prior Authorization. Please refer to the "Prior Authorization Requirement" section for details.

Laboratory and Diagnostic Imaging (including X-ray) Services

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

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

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 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.

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

Habilitative Services

Coverage for habilitative services and/or therapy is limited to Health Care Services and devices that help a person keep, learn, or improve skills and functioning for daily living, when provided by a Member Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical and mental health conditions, subject to any required Prior Authorization from Health Net. The services must be based on a treatment plan authorized, as required by Health Net and address the skills and abilities needed for functioning in interaction with an individual's environment.

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

Cardiac Rehabilitation Therapy

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

Pulmonary Rehabilitation Therapy

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

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. Clinical trial services performed by non-Participating Providers are covered only when the protocol for the trial is not available through a Participating Provider within California. Services rendered as part of a

An approved Clinical trial may be provided by a non-participating or Participating Provider subject to the reimbursement guidelines as specified in the law.

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

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

- The National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the federal Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs; or
- A cooperative group or center of any of the entities described above; or
- A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  1. The United States Department of Veterans Affairs;
  2. The United States Department of Defense;
  3. The United States Department of Energy; or
- The FDA as an Investigational new drug application.

"Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

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

Routine Physical Examinations

One routine physical examination (including psychological examinations or drug screening) per Calendar Year, requested by the Member without medical condition indications is covered. However, filling out forms related to the physical exam is not covered.

A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.

Please refer to "Annual routine physical examination" in the "Schedule of Benefits" section for Copayment requirements. See "Preventive Care Services" in this "Covered Services and Supplies" section for information about coverage of examinations that are for preventive health purposes.

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 for a diabetic condition or peripheral vascular disease. Additionally, treatment for cramping the feet, bunions and muscle trauma are covered only when Medically Necessary.

Pregnancy

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

Please refer to the "Schedule of Benefits" section, under the headings "Care for Conditions of Pregnancy" and "Inpatient Hospital Services" for Copayment and Coinsurance requirements.

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

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

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

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 card[or visit our website at www.healthnet.com/psbp.

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

Your Physician will not be required to obtain Prior Authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section Longer stays in the Hospital and scheduled or elective cesarean sections will require Prior Authorization. Please notify Health Net upon confirmation of pregnancy.

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

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

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

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

Medical Social Services

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

Home Health Care Services

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

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

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;

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

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

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

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

Outpatient Infusion Therapy

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

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

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

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

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

- Infusion medication administered in an outpatient Hospital setting that can be administered in the home or a non-Hospital infusion suite setting;
- 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.

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

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

Ambulance Services

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

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

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.

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

Nonemergency ambulance services and psychiatric transport van services are covered when Medically Necessary and when your conditions requires the use of services that only a licensed ambulance (or psychiatric transport van) 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.

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

Hospice Care

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

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

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

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

Durable Medical Equipment

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

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

Corrective Footwear (including specialized shoes, arch supports, and inserts) is covered when Medically Necessary and custom made for the Member.

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

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health Net will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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

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.

This Plan does not cover the following items:

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

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

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

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

Diabetic Equipment

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

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*

- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin, including pen needles*
- Specific brands of insulin needles and syringes*

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

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

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

Prostheses

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

Also covered are internally implanted devices such as heart pacemakers.

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

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

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

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

Prostheses are covered as shown under "Medical Supplies" in the "Schedule of Benefits" section.

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

Ostomy and Urological Supplies

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

- Ostomy adhesives - liquid, brush, tube, disc or pad
- Adhesive removers
- Belts - ostomy
- Belts - hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles - bedside and leg
- Dressing supplies
- Irrigation supplies
- Lubricants
- Miscellaneous supplies - urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches - urinary, drainable, ostomy
- Rings - ostomy rings
- Skin barriers
- Tape - all sizes, waterproof and nonwaterproof

Blood

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

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.

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

Outpatient Hospital Services

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

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

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

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

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

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.

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

Reconstructive Surgery

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

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

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

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

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

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the ***Women's Health and Cancer Rights Act of 1998****. In compliance with the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related*

services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also "Prostheses" in this "Covered Services and Supplies" section for a description of coverage for prostheses.

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.

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.

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

Telehealth Consultations Through the Select Telehealth Services Provider

Health Net contracts with certain Select Telehealth Services Providers to provide Telehealth Services for medical conditions and Mental Health 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 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" section and the coverage and Prior Authorization requirements, exclusions and limitations shown in the "Prescription Drugs" portions of the "Covered Services and Supplies" section and "Prescription Drugs/Outpatient Prescription Drugs" portion of the "Exclusions and Limitations" sections.

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.

Skilled Nursing Facility

Care in a room of two or more is covered. Benefits for a private room are limited to the facility's most common charge for a two-bed room, unless a private room is Medically Necessary. Covered 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" section.

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

Surgically Implanted Drugs

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of severe obesity is covered when Medically Necessary and authorized by Health Net.

When bariatric surgery is obtained through a Preferred Provider, you will be directed to a bariatric surgical center at the time authorization is obtained. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a Preferred Provider..

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

Approved travel-related expenses will be reimbursed as follows:

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

- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

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

- Expenses for tobacco, alcohol, telephone, television, recreation and any other expenses not specifically listed are excluded.

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

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

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.

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" section of this *Evidence of Coverage*. 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.

Vision and hearing examinations by an Out-of-Network Provider are not 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.

Renal Dialysis

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

You do not need Prior Authorization or a referral from Health Net or from any other person in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to

comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to the *Health Net PPO Provider Directory,* visit our website at www.healthnet.com/psbp or contact the Customer Contact Center at the phone number on your Health Net ID card.

Reproductive and Sexual Health Care Services

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

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

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

Treatment Related to Rape or Sexual Assault

This Plan provides Covered 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, and behavioral health care. These services will be covered in full when obtained through a Preferred Provider.

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

Immunizations and Injections

This Plan covers immunizations and injections (including infusion therapy when administered by a health care professional in the office setting), professional services to inject the medications and the medications that are injected.

This also includes allergy serum.

Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in the "Schedule of Benefits" section.

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

You can also call the Customer Contact Center telephone number listed on your Health Net ID card or visit our website at www.healthnet.com/psbp.

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" section.

Treatment of Infertility and fertility services is 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 Services for iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused directly or indirectly by surgery, chemotherapy, radiation or other medical treatment. Standard Fertility Preservation Services are procedures consistent with the established medical treatment practices and professional guidelines

published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

This benefit is subject to the applicable Copayments shown in the "Schedule of Benefits" section as would be required for Covered Benefits 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)

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.

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.

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 Prior Authorized by Health Net. Please refer to the "Prior Authorization Requirement" section for information on how to obtain Prior Authorization.

Health Net has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Physician can provide you with information about our Transplant

Performance Centers. You will be directed to a designated Health Net Transplant Performance Center at the time Prior Authorization is obtained. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

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

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

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

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.

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

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

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

Chiropractic Services

Chiropractic services are covered in accordance with the "Schedule of Benefits" section. Covered Benefits include:

- An initial examination is covered to determine the nature of your problem.
- Subsequent visits are covered up to the maximum number of visits stated in the "Schedule of Benefits" section, when Medically Necessary for the treatment of a Musculoskeletal and Related Disorders, as described in the proposed chiropractic treatment plan.
- Covered Benefits received during a subsequent visit may include manipulations, adjustments, therapy, x-ray procedures and laboratory tests in various combinations.

- X-ray services are also covered under this benefit when prescribed by a chiropractor and performed by another party.
- X-ray second opinions, however, will be a covered benefit only when performed by a licensed radiologist for verification of suspected tumors or fractures, not for routine care.

Acupuncture Services

Acupuncture services are covered in accordance with the "Schedule of Benefits" section. Covered Benefits include:

- A new patient exam or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of acupuncture services and to establish a treatment plan.
- Subsequent visits to receive acupuncture services as set forth in the treatment plan.
- 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.
- A re-examination may be performed by the Contracted Acupuncturist to assess the need to continue, extend or change a treatment plan. A re-examination may be performed during a subsequent office visit or separately. If performed separately, a Copayment or Coinsurance will be required.

Only the treatment of Pain, Nausea or Musculoskeletal and Related Disorders is covered, provided that the condition may be appropriately treated by a licensed 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).

Mental Health or Substance Use Disorder Benefits

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

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

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

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/psbp. You can also call the Health Net Customer Contact Center at the telephone number on your Health Net ID card to request the information.

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.

For additional information on accessing mental health services, visit our website at www.healthnet.com/psbp 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 "Introduction to Health Net" for more information.

How to Obtain Care – In Network

When you need to see a Participating Mental Health Professional, contact the Administrator 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 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 Health Net for review. Upon review and Prior Authorization (if Prior Authorization is required) by Health Net, the proposed services will be covered by this Plan if they are determined to be Medically Necessary.

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

For additional information on accessing mental health services, visit our website at www.healthnet.com/psbp or contact the Health Net Customer Contact Center phone number shown on your Health Net ID card.

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

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

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

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

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: (1) call your health plan at the telephone number on the back of your health plan identification card; (2) call the California Department of Managed 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.

How to Obtain Care – Out-of-Network

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

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

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

Emergency Services and Care , regardless of whether the Member is admitted, do not require Prior Authorization.

Covered Services and Supplies

Outpatient Services

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

Covered Benefits include:

- Outpatient office visits/professional consultation including Substance Use Disorders: Includes outpatient crisis intervention, assessment and treatment services, medication management (including detoxification), drug therapy monitoring, and specialized therapy including individual and group mental health evaluation and treatment.

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

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.

Inpatient Services

Inpatient treatment is covered as shown in the "Schedule of Benefits" 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.

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

Detoxification

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

Other Mental Health or Substance Use Disorders

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

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 may require Prior Authorization.

Prescription Drugs

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

Covered Drugs and Supplies

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

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

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

Tier 1 and Tier 2 Drugs listed in the Health Net Drug Formulary are covered, when prescribed by a Member Physician or an emergent or urgent care Physician. Some Tier 1 and Tier 2 Drugs require Prior Authorization from Health Net to be covered. The fact that a drug is listed in the 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. Brand Name Drugs that have generic equivalents will be dispensed when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, subject to the Copayment or Coinsurance requirements described in the "Prescription Drugs" portion of the "Schedule of Benefits" section.

Off-Label Drugs

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

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

B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and Seriously Debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the 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 (including those designed to assist the visually impaired) and test strips, ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section under "Diabetic Equipment" for additional information. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

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

Specialty Drugs

Specialty Drugs are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply. These drugs may have limited pharmacy availability or distribution and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously). Specialty Drugs are identified in the Health Net Formulary with “SP”. Refer to Health Net’s Formulary on our website at www.healthnet.com/psbp for the Specialty Drugs listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

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

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

Infertility Drugs

Infertility Drugs are covered when prescribed in connection with Infertility services that are covered by this Plan.

Other injectable medications are covered under the medical benefit (see the “Immunizations and Injections” portion of the “Covered Services and Supplies” section). Surgically implanted drugs are covered under the medical benefit (see the “Surgically Implanted Drugs” portion of the “Covered Services and Supplies” section).

Preventive Drugs and Contraceptives:

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member through a Participating Pharmacy. Covered preventive drugs are over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.

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/psbp. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

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

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

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

Weight Loss Drugs

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 Prior Authorization is required. If the generic version exists, it will be dispensed instead of the brand name version.

You may call the Customer Contact Center at the telephone number on your Health Net ID card to find out if a particular drug is listed in the 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/psbp.

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 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 information and medications are approved by the FDA.

Who is on the Pharmacy and Therapeutic Committee and How are Decisions Made?

The Committee is made up of actively practicing Physicians of various medical specialties from Health Net Physician groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the 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 a Member. For more information on the step therapy exception process, please see "Step Therapy Exception" in the Essential Drug List on www.healthnet.com/psbp.

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/psbp 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.

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

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

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

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

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

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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/psbp or call the Customer Contact Center at the telephone number on your Health Net ID card. Present the Health Net ID card and pay the appropriate Copayment when the drug is dispensed.

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

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

If the Health Net ID card is not available or eligibility cannot be determined:

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

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

If you elect to pay out-of-pocket and submit a prescription claim directly to Health Net instead of having the contracted pharmacy submit the claim directly to Health Net, you will be reimbursed based on the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription, less any applicable Deductible, Copayment or Coinsurance.

Prescription Drugs at Nonparticipating Pharmacies

Prescription Drugs dispensed for Emergency Services and Care or Urgently Needed Care are covered at the in-network benefit level. Health Net will reimburse you for the cost of the Prescription Drug, less any applicable Deductible, Copayment or Coinsurance shown for Participating Pharmacy in the "Schedule of Benefits" section under "Prescription Drugs."

For all other Prescription Drugs dispensed by a Nonparticipating Pharmacy, the maximum charge Health Net will allow for a Prescription Drug Order is the Prescription Drug Covered Expense, as defined in the "Definitions" section. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the amount of Prescription Drug Covered Expense in addition to the applicable Deductible, Copayment or Coinsurance. If you present a Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available.

When Prescription Drugs are dispensed by a Nonparticipating Pharmacy, you will be required to:

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

To receive the highest available benefits for Prescription Drugs under this Plan, you must have the Prescription Drug Order dispensed by a Participating Pharmacy, and request that Generic Drugs be substituted for Brand Name Drugs.

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

Drugs Dispensed by Mail Order

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

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

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

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 or Coinsurance applies each time a drug is dispensed. In some cases, a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the mail order may be less than a 90-consecutive-calendar-day supply.

Maintenance drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.

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

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" 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" 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 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 besity. 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 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 "When Coverage Ends" in the "Eligibility, Enrollment and Termination" section regarding termination for nonpayment, Health Net will not provide notice of such changes to Plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to Plan Subscribers.

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

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

Prior Deductible Carryover Credit

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

Members' Rights, Responsibilities and Obligations Statement

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

As a Member, 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:

- 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 Benefits.
- 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 an Experimental Service, Investigational Service, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center or at **1-888-893-1572** or by submitting a Member grievance form through the Health Net website at www.healthnet.com/psbp. 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

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

We will:

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

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility

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

1. Your provider has recommended a Health Care Service as Medically Necessary; you have received urgent or Emergency 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 Health Net's Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com/psbp.

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 Service or Investigational Service and you meet the eligibility criteria set out below, you may request an independent Medical Review ("IMR") of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or

Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.
2. Your Physician must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by Health Net.
3. Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or, as an alternative, you submit a request for a therapy that, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
4. You have been denied coverage by Health Net for the recommended or requested therapy.
5. If not for Health Net's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

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

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against your health plan, you should first telephone your health plan at **1-888-893-1572** and use our grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by 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 the total damages are over $500,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

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

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

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

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 Services Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational Services or Experimental Services 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 Services 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 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 provider's effort to obtain reimbursement, including:

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

How the Amount of Your Reimbursement is Determined

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

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount,

the value of the services depends on how the provider was paid, as summarized below, and will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by law.

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

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

Surrogacy Arrangements

A Surrogacy Arrangement is an arrangement in which a 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

Participating Providers, Hospitals and other health care providers are not agents or employees of Health Net.

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

All of the parties are independent contractors and contract with each other to provide you the Covered Benefits of this Plan.

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Contracting Administrators

Health Net may designate or replace any contracting administrator that provides the Covered 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.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a Preferred Provider is terminated, Health Net will make every effort to ensure continuity of care. A Member may request continued care from an Out-of-Network Provider at the in-network benefit level, if at the time of provider contract termination the Member was receiving care from such a provider for the conditions listed below. For providers and Hospitals that end their contract with Health Net, a written notice will be provided to Members with open authorizations within five days after the effective date of the contract termination.

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

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

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

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

Coordination of Benefits

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

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

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

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

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

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

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

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Examples of these provisions are second surgical opinions, prior authorization of admissions and Preferred Provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

- The parents are married; or
- The parents are not separated (whether or not they ever have been married); or

- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

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

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

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

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

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

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

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

5. **Longer or Shorter Length of Coverage**--If the preceding rules do not determine the order or payment, the Plan that covers the subscriber (non-dependent), retiree or dependent of either for the longer period is primary.

   a. **Two Plans Treated As One**--To determine the length of time a person has been covered under a Plan; two Plans shall be treated as one if the Member was eligible under the second within twenty-four hours after the first ended.

   b. **New Plan Does Not Include**--The start of a new Plan does not include:

      i. A change in the amount or scope of a Plan's benefits.

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

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

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

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

Effect on the Benefits of this Plan

A. **Secondary Plan Reduces Benefits**--When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100% of total Allowable Expenses.

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

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

Right to Receive and Release Information

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

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

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

Health Net's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If the "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Government Coverage

Medicare Coordination of Benefits (COB)

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

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

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the Covered 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 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, Health Net will cover the services then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits

In most instances, you will not need to file a claim when you receive Covered Benefits from a Preferred Provider. If you use an Out-of-Network Provider and file a claim, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Deductible, Copayment or Coinsurance, and the amount in excess of the Maximum Allowable Amount. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

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

Notice of Claim

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

Call the Health Net Customer Contact Center at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com/psbp to obtain claim forms.

If you need to file a claim for services covered under the medical or Mental Health or Substance Use Disorder benefit, please send a completed claim form to:

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

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

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

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

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).

Payment of Claim

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

Payment to Providers or Subscriber

Benefit payment for Covered Expenses will be made directly to:

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

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

Payment When Subscriber is Unable to Accept

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

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Physical Examination

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

Foreign Travel or Work Assignment

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

Out-of-State Providers

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

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

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

Interpretation of *Evidence of Coverage*

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

Disruption of Care

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

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary Covered 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 "Introduction to Health Net."

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. The *Evidence of Coverage*, however, will be posted electronically on Health Net's website at www.healthnet.com/psbp. The Group can opt for the Subscribers to receive the *Evidence of Coverage* online. By registering and logging on to Health Net's website, Subscribers can access, download and print the *Evidence of Coverage*, or can choose to receive it by U.S. mail, in which case Health Net will mail the *Evidence of Coverage* to each Subscriber's address on record.

If the Subscriber or the Group is required to provide notice, the notice should be mailed to the Health Net office at the address listed on the back cover of this *Evidence of Coverage*.

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. **Effective: 08.14.2017**

Covered Entities Duties:

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

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

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

- The Uses or disclosures
- Your rights
- Our legal duties; 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.
- We keep our offices secure.

***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., Health Net Health Plan of Oregon, Inc., and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation. Rev. 09/05/2025.

- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

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

- ***Treatment -*** We may use or disclose your PHI to a Physician or other Health Care Provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the Health Care Services provided to you. We may disclose your PHI to another health plan, to a Health Care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity; and for
  - performing utilization review of claims
- ***Health Care Operations*** - We may use and disclose your PHI to perform our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination; and
  - conducting medical review of claims and other quality assessment
  - improvement activities

  In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must have a relationship with you for its health care operations. This includes the following:
  - quality assessment and improvement activities
  - reviewing the competence or qualifications of health care professionals
  - case management and care coordination
  - detecting or preventing health care fraud and abuse.

  Your race, ethnicity, language, sexual orientation, and gender identity, and social needs information are protected by the health plan's systems and laws. This means information you provide is private

and secure. We can only share this information with California regulatory agencies, Health Care Providers, and health care oversight entities. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:

- better understand your health care needs;
- know your language preference when seeing health care providers;
- providing health care information to meet your care needs;
- and offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

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

- ***Judicial and Administrative Proceedings -*** We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court;
  - administrative tribunal;
  - subpoena;
  - summons;
  - warrant;
  - discovery request; or
  - similar legal request.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - court order;
  - court-ordered warrant;
  - subpoena;
  - summons issued by a judicial officer; or
  - grand jury subpoena.

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- ***Substance Use Disorder Records (SUD)*** – We will not use or disclose your SUD records in legal proceedings against you unless:
  - We receive your written consent, or
  - We receive a court order; you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - cadaveric organs
  - eyes, and
  - tissues.
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - to authorized federal officials for national security and intelligence activities
  - the Department of State for medical suitability determinations, and
  - for protective services of the President or other authorized persons
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

- ***Sale of PHI*** – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing*** – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- ***Psychotherapy Notes*** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- ***Impermissible Use of PHI*** – We will not use your language, race, ethnic background, sexual orientation, 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. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

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

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

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-888-893-1572
Fax: 1-883-887-0151
Email: Privacy@healthnet.com

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer
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.

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.

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 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 drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

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

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

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer, and still under patent, and is advertised and sold under that name and indicated as a brand in the Medi-Span or similar third party national database used by Health Net.

Calendar Year is the continuous twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

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

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

Contracted Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (ASH Plans) to provide covered acupuncture services to Members.

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

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

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

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

Covered 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.

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

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment

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

Domestic Partner is, for the purposes of this *Evidence of Coverage*, the Subscriber's partner if the Subscriber and partner are a couple who are domestic partners that meet all the requirements of Sections 297 or 299.2 of the California Family Code.

Drug Discount or **Coupon** or **Copay Card** means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or Coinsurance or your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum.)

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the Plan.

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 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 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.

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 Services and Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Services and Care or Urgently Needed Care.

Formulary (also known as the Drug List) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com/psbp. 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 California licensed health care service plan.

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

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

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in their place of residence that is prescribed by the Member's attending Physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this Plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

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

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

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.

Maternal Mental Health means a Mental Health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

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

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

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary 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.

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

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

Member 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.

Mental Health or Substance Use Disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

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.

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about health care.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted or on any date approved by Health Net.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Network Providers are Physicians, Hospitals, laboratories or other providers of health care who are not part of the Health Net Preferred Provider Organization (PPO) or the supplemental network outside of California, except as noted under the definitions for ““Transplant Performance Center.”

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

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health or Substance Use Disorder rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section. Services provided by a mental health professional under the out-of-network benefit level must meet these same licensing requirements.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Participating Providers (See "Preferred Providers" definition)

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

- Dentist (D.D.S.)
- Optometrist (O.D.)
- Dispensing optician
- Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- Psychologist
- Chiropractor (D.C.)
- Acupuncturist (A.C.)
- Nurse midwife
- Nurse Practitioner
- Physician Assistant
- Clinical social worker (M.S.W. or L.C.S.W.)
- Marriage, family and child counselor (M.F.C.C.)
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist
- Audiologist
- Occupational therapist (O.T.R.)

- Psychiatric mental health nurse
- Respiratory care practitioner
- Other Mental Health or Substance Use Disorder providers, including, but not limited to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

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

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

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

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

Prescription Drug Order is a written or verbal order, or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness or injury and which is issued by a Physician within the scope of their professional license.

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

sections. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- maintain good health
- prevent or lower the risk of diseases or illnesses
- detect disease or illness in early stages before symptoms develop
- monitor the physical and mental development in children

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements not otherwise specified in this document, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization and Step Therapy Exception 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 enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the protected individual has the right to consent to care.

Psychiatric Emergency Medical Condition means 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; and
     ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional; and
  F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to

improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a Telehealth Service provider that is contracted with Health Net to provide Telehealth Services that are covered under the "Telehealth Consultations Through the Select Telehealth Services Provider" heading as shown in the "Schedule of Benefits" and "Covered Services and Supplies" sections. The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Sensitive Services means all Health Care Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929, 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

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 Physician who delivers specialized services and supplies to the Member.

Specialty Drugs are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply.

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 state 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.

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.

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.

Transplant Performance Center is a provider in Health Net's designated network in California or the supplemental network (outside of California) for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network and the supplemental network's of Transplant Performance Centers includes any providers in Health Net's or the supplemental network's designated supplemental resource network. Preferred Providers that are not designated as part of Health Net's or the supplemental network's Transplant Performance Centers are

considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services. See the "Out-of-State Providers" provision in the "Miscellaneous Provisions" section for additional information.

Urgently Needed Care includes otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of their health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

Language Assistance Services

Health Net provides free language assistance services, such as , in-person interpretation, telephone interpretation, video remote interpretation, sign language interpretation, translated written materials, oral translations and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual/multilingual staff and interpreter services for additional languages to handle 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 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 Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníłł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

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.

FLY065732EP00 (11/24)

Contact us

Health Net PPO
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 Business Group:
1-800-361-3366 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)

www.healthnet.com/psbp