health net

Amendment to Your Medical Coverage

Please read the following amendment to your Health Net Evidence of Coverage ("EOC") carefully. It contains changes to your health coverage.

THIS AMENDMENT is part of the *EOC*. Unless otherwise indicated herein, all terms initially capitalized herein shall have the same meaning attributed to such terms in the *EOC* and references to applicable sections of the *EOC*. Please attach this Notice to your *EOC*. This Amendment, combined with your *EOC*, explain the details of your health care coverage. If you have questions about this Notice, please contact Health Net Customer Contact Center at the telephone number on Your Health Net ID card.

The provisions below supersede and replace the noted provisions in your *EOC*. All other terms and conditions shown in your *EOC* will continue to apply. The new text is underlined and deleted text is ~~struck out~~ as shown below:

Changes to Coverage Terms Effective *January 1, 2026*

1. Introduction to Health Net

a. The "Introduction to Health Net" of your EOC is modified to include the following language:

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

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

2. The "Schedule of Benefits" section of your EOC is revised as follows:

a. Under Infertility Services, the benefit language and related notes are revised as follows:

	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~~ retrievals ~~cycles~~ per lifetime~~)~~ and 3 completed retrievals of sperm per lifetime) and all Covered Benefits that prepare the Member to receive~~ this procedure~~ these procedures, are covered ~~only for the Health Net Member~~.

- Injections for Infertility are covered only when provided in connection with services that are covered by this Plan.
- 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" if Prior Authorization is required but not obtained.
- *Applicable Deductible or Copayment or Coinsurance requirements apply to any services and supplies required for Infertility services. For example, if the Infertility service requires an office visit, then the office visit Copayment will apply.

3. The "Covered Services and Supplies" section of your *EOC* is revised as follows:

a. Under Infertility Services, the benefit language and related notes are revised as follows:

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.
- <u>Oocyte retrievals up to a lifetime maximum of 3 completed oocyte retrievals; and</u>
- <u>3 completed sperm retrievals per lifetime; and</u>
- <u>Cryopreservation and storage of sperm, oocytes, and embryos for a period of five years from the time the genetic material is first cryopreserved.</u>

<u>If a Member is using the services of a surrogate to treat the Infertility of the Member, in addition to the above-described services, the Member's health plan shall cover Medically Necessary health testing of the surrogate, as necessary, for each attempt to collect eggs or sperm or to create embryos, and for each attempt to achieve a pregnancy with that material.</u>

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 retrievals have been met.
- Retrieval of sperm beyond a lifetime maximum of 3 retrievals; and
- Cryopreservation and storage of sperm, oocytes, and embryos beyond a period of five years from the time the genetic material is first cryopreserved.

The Member's health plan shall not be responsible for health care costs of the surrogate after the embryo transfer procedure, including maternity services, except as required by law.

Infertility services are subject to the Copayments and benefit limitations, as shown 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.

If you need additional information, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

4. The "Exclusions and Limitations" section of your *EOC* is revised as follows:

a. Under Surrogate Pregnancy, the exclusion language is revised as follows:

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 "Infertility Services" provision in the "Covered Services and Supplies" section, the "Surrogacy Arrangements" provision in the "General Provisions" section, or as required by law.

HEALTH NET OF CALIFORNIA