A COMPLETE

explanation

of your plan

Health Net of California, Inc. IEX

Plan Contract and Evidence of Coverage

Health Net Platinum 90 CommunityCare HMO AI AN

PLAN H7B

EOCID: 579621

Important benefit information - please read

Health Net®

Amendment to Your Medical Coverage

Please read the following Amendment to your Health Net Individual and Family Plan Contract and Evidence of Coverage ("EOC") carefully. It contains changes to your health care coverage.

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

Effective January 1, 2021, coverage language for mental health and substance use disorder (MH/SUD) treatment has been revised to comply with California Senate Bill 855, which passed into law on September 25, 2020.

The provisions below supersede and replace the noted provisions in your *Plan Contract and EOC*. All other terms and conditions shown in your *Plan Contract and EOC* will continue to apply.

Changes to Coverage Terms Effective *January 1, 2021*

1. **The "Mental Disorders and Chemical Dependency Benefits" portion of the "Schedule of Benefits and Copayments" of your *Plan Contract and Evidence of Coverage* has been renamed "Mental Health and Substance Use Disorder Benefits."**
2. **The "Mental Disorders and Chemical Dependency" subsection in the "Covered Services and Supplies" section of your *Plan Contract and Evidence of Coverage* has been renamed "Mental Health and Substance Use Disorders."**
3. **The "Definitions" section of your *Plan Contract and Evidence of Coverage* is revised as follows:**
    a. *The definitions of "Chemical Dependency" and "Mental Disorders" have been removed and replaced in their entirety with a new definition for "Mental Health and Substance Use Disorders" and will read as follows. All references to "Chemical Dependency" and "Mental Disorders" have been changed to reflect the new term throughout the Plan Contract and Evidence of Coverage. In addition, the definitions of "Serious Emotional Disturbances of a Child" and "Severe Mental Illness" have been deleted in their entirety and references of these terms have been deleted throughout the Plan Contract and Evidence of Coverage.*

    Mental Health and 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. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition

is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

b. *The definition for "Medically Necessary (or Medical Necessity)" has been replaced in its entirety as shown below:*

Medically Necessary (or Medical Necessity)

For services other than Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means Health Care Services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

For Treatment of Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) 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 Mental Health and 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 subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

- "Health care provider" means any of the following:
  - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
  - An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
  - A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
  - An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
  - An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
  - A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
  - A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
  - A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

HEALTH NET OF CALIFORNIA

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

Except for Emergency Care, benefits for Physician and Hospital services under this **Health Net HMO CommunityCare Network** ("CommunityCare Network") plan are only available when you live or work in the CommunityCare Network service area and use a CommunityCare Network Physician or Hospital. However, if you receive covered services at a CommunityCare network health facility at which or as a result of which you receive services provided by a non-contracted provider, you will pay no more than the same cost sharing you would pay for the same covered services received from a CommunityCare network provider. When you enroll in this CommunityCare Network plan, you may only use a Physician or Hospital who is in the CommunityCare Network, except as noted above, and you must choose a CommunityCare Network Primary Care Physician. You may obtain ancillary, Pharmacy or Behavioral Health covered services and supplies from any Health Net Participating ancillary, Pharmacy or Behavioral Health Provider.

Obtaining Covered Services under the Health Net HMO CommunityCare Network Plan

Type of Provider	Available From
HOSPITAL	*Only CommunityCare Network Hospitals
PHYSICIAN	*Only CommunityCare Network Physicians
ANCILLARY	All Health Net Contracting Ancillary Providers
PHARMACY	Only Health Net Advanced Choice Pharmacy Network
BEHAVIORAL HEALTH	All Health Net Contracting Behavioral Health providers

* The benefits of this plan for Physician and Hospital services are only available for covered services received from a CommunityCare Network Physician or Hospital, except for (1) Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care; (2) referrals to non-CommunityCare Network providers are covered when the referral is issued by your CommunityCare Network Physician Group; and (3) covered services provided by a non-CommunityCare Network provider when authorized by Health Net. Please refer to the "Introduction to Health Net" section for more details on referrals and how to obtain Emergency Care.

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

The CommunityCare Network service area and a list of its Physician and Hospital providers are shown in the Health Net *CommunityCare Network Provider Directory*, which is available online at our website www.myhealthnetca.com. You can also call the Health Net Customer Contact Center at **1-888-926-4988** to request provider information. The *CommunityCare Network Provider Directory* is different from other Health Net Provider Directories.

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

- Health Net
- Health Net Service Area

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

Health Net Advanced Choice Pharmacy Network

Not all pharmacies that contract with Health Net are in the Health Net Advanced Choice Pharmacy Network. Except in an emergency, only those pharmacies specifically identified as participating in the Advanced Choice Pharmacy Network may provide the Prescription Drugs benefit under this plan. For a list of pharmacies participating in the Advanced Choice Pharmacy Network, call our Health Net Customer Contact Center or visit our website at www.myhealthnetca.com. Pharmacies that are not in the Advanced Choice Pharmacy Network are considered Nonparticipating Pharmacies under this Plan.

Unless specifically stated otherwise, use of the following terms in this Plan Contract and Evidence of Coverage solely refers to the Advanced Choice Pharmacy Network as explained above.

- Participating Pharmacy
- Health Net contracting retail pharmacy
- Contracted pharmacy

If you have any questions about the CommunityCare Network Service Area, choosing your Community Care Network Primary Care Physician, how to access Specialist care or your benefits, please contact the Health Net Customer Contact Center at **1-888-926-4988**.

Health Net CommunityCare Network Alternative Access Standards

The CommunityCare Network includes participating primary care and Specialist Physicians, and Hospitals in the CommunityCare service area. However, CommunityCare Members residing in the following zip codes will need to travel as indicated to access a participating PCP and/or receive non-emergency Hospital services.

16– 30 Miles

Kern County: **93203** – Arvin (Hospital), **93255** – Onyx (Hospital), **93313** – Bakersfield (Hospital), **93560** – Rosamund (PCP and Hospital)

Los Angeles County: **91301** – Agoura Hills (Hospital), **91310** – Castaic (Hospital), **91354** – Valencia (Hospital), **91355** – Valencia (Hospital), **91361** – Westlake Village (Hospital), **91383** – Santa Clarita (Hospital), **91384** – Castaic (Hospital), **91390** – Santa Clarita (Hospital), **93535** – Lancaster (PCP), **93536** – Lancaster (PCP), **93543** – Littlerock (Hospital), **93591** – Palmdale (Hospital)

Orange County: **92672** – San Clemente (Hospital), **92673** – San Clemente (Hospital)

Riverside County: **92274** – Thermal (Hospital), **92544** – Hemet (Hospital)

San Bernardino County: **92315** – Big Bear Lake (Hospital), **92333** – Fawnskin (Hospital), **92342** – Helendale (Hospital), **92397** – Wrightwood (Hospital)

San Diego County: **91901** – Alpine (Hospital), **91917** – Dulzura (Hospital), **91987** – Tecate (Hospital), **92021** – El Cajon (Hospital), **92060** – Palomar Mountain (Hospital)

Beyond 30 Miles

Kern County: **93206** – Buttonwillow (Hospital: 40 miles), **93222** – Pine Mountain Club (Hospital: 44 miles), **93224** – Fellows (Hospital: 35 miles), **93225** – Frazier Park (Hospital: 45 miles), **93243** – Lebec (Hospital: 47 miles), **93249** – Lost Hills (Hospital: 61 miles), **93251** – McKittrick (PCP: 35 miles and Hospital: 49 miles), **93252** – Maricopa (Hospital: 45 miles), **93255** – Onyx (PCP: 32 miles), **93268** – Taft (Hospital: 38 miles), **93501** – Mojave (Hospital: 33 miles), **93504** – California City (Hospital: 34 miles), **93505** – California City (Hospital: 35 miles), **93516** – Boron (PCP: 32 miles and Hospital: 52 miles), **93519** – Cantil (PCP: 37 miles and Hospital: 57 miles), **93523** – Edwards Air Force Base (Hospital: 45 miles), **93524** – Edwards Air Force Base (PCP: 34 miles and Hospital: 50 miles), **93596** – Boron (Hospital: 51 miles)

Los Angeles County: **90704** – Avalon (PCP: 70 miles and Hospital: 35 miles); **90265** - Malibu (Hospital: 32 miles), **93532** – Lake Hughes (Hospital: 40 miles), **93535** – Lancaster (Hospital: 33 miles), **93536** – Lancaster (Hospital: 36 miles), **93544** – Llano (Hospital: 32 miles)

Riverside County: **92254** – Mecca (Hospital: 36 miles), **92536** – Aguanga (Hospital: 34 miles), **92539** – Anza (Hospital: 34 miles)

San Bernardino County: **92277** – Twentynine Palms (Hospital: 35 miles), **92278** – Twentynine Palms (PCP: 46 miles), **92285** – Landers (Hospital: 38 miles), **92301** – Adelanto (Hospital: 32 miles), **92305** – Angelus Oaks (Hospital: 33 miles), **92309** – Baker (PCP: 109 miles and Hospital: 129 miles), **92310** – Fort Irwin (PCP: 45 miles and Hospital: 71 miles), **92311** – Barstow (Hospital: 39 miles), **92312** – Barstow (Hospital: 37 miles), **92314** – Big Bear City (Hospital: 33 miles), **92327** – Daggett (Hospital: 47 miles), **92347** – Hinkley (Hospital: 41 miles), **92356** – Lucerne Valley (Hospital: 32 miles), **92365** – Newberry Springs (PCP: 35 miles and Hospital: 60 miles), **92386** – Sugarloaf (Hospital: 32 miles), **92398** – Yermo (Hospital: 50 miles), **93516** – Boron (PCP: 32 miles and Hospital: 52 miles)

San Diego County: **91905** – Boulevard (Hospital: 51 miles), **91906** – Campo (Hospital: 45 miles), **91916** – Descanso (Hospital: 33 miles), **91931** – Guatay (Hospital: 34 miles), **91934** – Jacumba (Hospital: 57 miles), **91948** – Mt. Laguna (Hospital: 42 miles), **91962** – Pine Valley (Hospital: 45 miles), **91963** – Potrero (Hospital: 35 miles), **91980** – Tecate (Hospital: 31 miles), **92004** – Borrego Springs (PCP: 37 miles and Hospital: 51 miles), **92036** – Julian (PCP: 31 miles and Hospital: 53 miles), **92059** – Pala (Hospital: 34 miles), **92066** – Ranchita (PCP: 34 miles and Hospital: 44 miles), **92070** – Santa Ysabel (Hospital: 32 miles), **92086** – Warner Springs (Hospital: 40 miles)

Health Net CommunityCare HMO Network Alternative Access Standards – Ancillary Providers

The CommunityCare Network includes participating ancillary providers, including acupuncture, vision and dental services providers, in the CommunityCare service area. However, in the rural zip codes within the service area identified below, Health Net may not have a contracted provider for acupuncture, vision and/or dental services. If you require medically necessary services from an acupuncture, vision and/or dental services provider in these areas where Health Net does not have a contracted provider for acupuncture, vision and/or dental services, and there are nonparticipating acupuncture, vision and/or dental providers offices located within access standards, Health Net's applicable ancillary provider networks will make arrangements with a nonparticipating acupuncture, vision and/or dental services provider within the access standards who will provide the services to you at the copayment levels described in the "Schedule of Benefits and Copayments" section of this Plan Contract and EOC.

Acupuncture:

Kern County: **93205** (Bodfish), **93240** (Lake Isabella), **93283** (Weldon), **93505** (California City), **93519** (Cantil), **93523** (Edwards) and **93561** (Tehachapi)

Los Angeles County: **90704** (Avalon)

San Bernardino County: **92277** (Twentynine Palms), **92309** (Baker), **92310** (Fort Irwin), **92327** (Daggett) and **92365** (Newberry Springs)

Dental:

Primary Care Dentists and General Dentists:

Kern County: **93205** (Bodfish), **93222** (Pine Mountain Club), **93225** (Frazier Park), **93226** (Glennville), **93238** (Kernville), **93240** (Lake Isabella), **93243** (Lebec), 93249 (Lost Hills), **93255** (Onyx), **93283** (Weldon), **93285** (Wofford Heights), **93287** (Woody), **93313** (Bakersfield), **93501** (Mojave), **93504** (California City), **93505** (California City), **93516** (Boron), **93518** (Caliente), **93519** (Cantil), **93523** (Edwards), **93524** (Edwards), **93596** (Boron)

Los Angeles County: **90704** (Avalon), **93243** (Lebec), **93535** (Lancaster), **93536** (Lancaster), **93543** (Littlerock), **93544** (Llano), **93563** (Valyermo), **93591** (Palmdale)

Riverside County: **92539** (Anza)

San Bernardino County: **92277** (Twentynine Palms), **92278** (Twentynine Palms), **92285** (Landers), **92301** (Adelanto), **92309** (Baker), **92310** (Fort Irwin), **92314** (Big Bear City), **92315** (Big Bear Lake), **92365** (Newberry Springs), **92356** (Lucerne Valley), **92386** (Sugarloaf), **92333** (Fawnskin)

San Diego County: **91905** (Boulevard), **91906** (Campo), **91916** (Descanso), **91931** (Guatay), **91934** (Jacumba), **91962** (Pine Valley), **91963** (Potrero), **91980** (Tecate), **92036** (Julian), **92065** (Ramona)

Health Net®

Plan Contract and Evidence of Coverage ("Plan Contract")

ISSUED BY

Health Net of California, Inc.

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Plan Contract and Evidence of Coverage ("Plan Contract") provides for comprehensive health services provided through Health Net of California, Inc. (Health Net). Although, Health Net is a federally qualified Health Maintenance Organization and a California Health Care Service Plan, this health plan is not a federally qualified product. Upon payment of subscription charges in the manner provided for in this Plan Contract, Health Net hereby agrees to furnish services and benefits as defined in this Plan Contract to eligible Subscribers and their eligible Family Members according to the terms and conditions of this Plan Contract.

Plan Code: H7B

Health Net

Douglas Schur
Secretary

J. Brian Ternan
President

Use of Special Words

Special words used in this Plan Contract to explain your Plan have their first letter capitalized and appear in "Definitions," Section 1100.

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 accepted for enrollment.
- "**We**" or "**Our**" refers to Health Net.
- "**Subscriber**" means the primary Member.
- "**Member**" is the Subscriber or an enrolled family member.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the Health Net contracting medical group the individual Member selected as the source of all covered medical care.
- "**Primary Care Physician**" is the individual physician each Member selected who will provide or authorize all covered medical care.
- "**Plan**" and "**Plan Contract and Evidence of Coverage (EOC)**" have similar meanings. You may think of these as meaning your Health Net benefits.

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About This Booklet

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

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. The Member may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Health Net ID Card.

Section-100

TERM OF YOUR COVERAGE (SECTION 100)

For Subscribers and any of their Family Members whose application for enrollment is accepted by Health Net, this Plan Contract becomes effective on the date stated on your Notice of Acceptance, at 12:00 midnight and will remain in effect, subject to the payment of subscription charges as set below. You may terminate this Plan Contract by notifying Covered California or Health Net at least 14 days before the date that you request that the Plan Contract terminate. In such event, the Plan Contract will end at 12:01 a.m. 14 days after you notify Covered California or Health Net, on a later date that you request, or on an earlier date that you request if Health Net agrees to the earlier date. Health Net may terminate or not renew this Plan Contract for causes as set forth in "Termination for Cause," Section 600, Subsection G. If the terms of this Plan Contract are altered by Health Net, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Section-200

SUBSCRIPTION CHARGES (SECTION 200)

For Subscribers, the first Subscription Charge payment must be paid to Health Net on or before the Effective Date of this Plan Contract. After that, payment is due on or before the first day of each coverage month (the first of each coverage quarter for quarterly billing) while the Plan Contract is in effect. Subscription charges are payable by the Subscriber and are based on the type of Family Unit and are set out on the Notice of Acceptance. Subscription charges must be paid in advance once a month in full for each member receiving coverage for any portion of the month, including those members whose coverage commences during the month and those members whose coverage terminates during the month. Regarding coverage of newly born or newly adopted children, see the “Newly Acquired Dependents” portion of the “Eligibility, Enrollment and Termination” section.

This Plan Contract may be terminated by Health Net after a 30 day grace period which begins on the first day after the last day of paid coverage. Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the Plan Contract. Before the 30 day grace period begins, Health Net will send a “Notice of Consequences for Nonpayment of Premiums” that will confirm your premium due date and describe the 30 day grace period.

If you do not pay your subscription charges by the first day of the month for which subscription charges are due, Health Net will send a late payment notice which will provide: (a) dollar amount due which

must be paid in full in order to avoid termination of coverage; (b) date of the last day of paid coverage; (c) names of all enrollees affected by the notice; (d) additional information regarding the grace period; (e) consequences of losing coverage for nonpayment of Subscription Charges; and (e) the date the grace period begins and expires.

If payment is not received by the end of the 30 day grace period, the Plan Contract will be cancelled. Health Net will mail a termination notice that will provide the following information: (a) that the Plan Contract has been cancelled for non-payment of Subscription Charges; (b) the specific date and time when coverage is terminated for the Subscriber and all Dependents; and (c) your right to submit a grievance.

Subscribers and enrolled Dependents who are receiving Federal Advance Payment of the Premium Tax Credit or California Premium Subsidy have a three month grace period instead of a 30 day grace period. Please read the subsection below, "If You Are Receiving Federal Advance Payment of Premium Tax Credits or a California Premium Subsidy," for information about the three month grace period and the consequences for non-payment of subscription charges.

For individuals who do not qualify for the three month grace period, Health Net will allow one reinstatement during any twelve-month period, if the amounts owed are paid within 15 days of the date the notice confirming your termination is mailed. If you do not obtain reinstatement of the cancelled Plan Contract within the required 15 days or if the Plan Contract has previously been cancelled for non-payment of subscription charges during the previous contract year, then Health Net is not required to reinstate you and you will need to reapply for coverage. Amounts received after the termination date will be refunded to you by Health Net within 20 business days.

The Subscriber can pay the subscription charges by any one of the following options: monthly automatic deduction from a personal checking account, check, cashier's check, money order, debit card or credit card, or general purpose pre-paid debit card.

Subscription payments by a paper check, cashier's check, or money order should be mailed to:

Health Net
P.O. Box 748705
Los Angeles, CA 90074-8705

Call Health Net's Automated Payment System, **1-800-539-4193**, to make a payment by check, debit card, or credit card, or general purpose pre-paid debit card.

NOTE: This address is for initial application submission:

Health Net Individual and Family Enrollment Unit
P.O. Box 1150
Rancho Cordova, CA 95741-1150

Retroactive adjustments for additions for any Family Members will be made in subsequent billings, but in no event will the effective date be more than 30 days prior to the date Health Net received the written request.

Subscription charges may be changed by Health Net effective January 1st of each year with at least a 60 days written notice to the Subscriber prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If this Plan Contract is terminated for any reason, the Subscriber shall be liable for all subscription charges for any time this Plan Contract is in force during any notice period.

If You Are Receiving Federal Advance Payment of Premium Tax Credits or a California Premium Subsidy

The information provided above may not apply to you. Here are the differences that apply to you.

Subscribers and enrolled Dependents for whom Health Net receives Federal Advance Payment of Premium Tax Credits (APTC) or a California Premium Subsidy have a three-month grace period for failure to pay subscription charges. This three-month grace period is instead of the 30 day grace period described above. Health Net will NOT send you the 30 day grace period written notice described for Subscribers who do not receive APTC. Instead, if you do not pay outstanding subscription charges for each Family Member receiving coverage for the month by the first day of the month for which Subscription Charges are due, Health Net will send you a late payment notice. If you do not pay outstanding subscription charges for each Family Member receiving coverage for the month by the 15th day of the month for which subscription charges are due, Health Net will send you a suspension of coverage notice. Both notices will provide: (a) dollar amount due which must be paid in full in order to exit the three-month grace period; (b) date of the last day of paid coverage; (c) names of all enrollees affected by the notice; (d) additional information regarding the grace period; (e) consequences of losing coverage for nonpayment of Subscription Charges; and (f) the date the three-month grace period begins and expires. The suspension of coverage notice will provide the start and end dates of the suspension of coverage and information regarding your right to submit a grievance.

If you DO NOT pay the entire amount of outstanding subscription charges in full before the end of the three-month grace period, Health Net will terminate your coverage and indicate that your coverage effectively ended on the first day of the second month of your three-month grace period. Health Net will mail a termination notice which will provide the following information: (a) that the Plan Contract has been cancelled for non-payment of Subscription Charges; (b) the specific date and time when coverage is terminated for the Subscriber and all Dependents; and (c) your right to submit a grievance. If your coverage terminates for this reason, you will not be allowed to reinstate coverage after the three month grace period ends and your coverage will terminate effective as of the first day of the second month of your grace period.

Health Net will cover all allowable claims for the first month of the three-month grace period. However, Health Net will suspend your coverage and pend claims for services rendered by health care providers in the second and third months of the three-month grace period. If Health Net ultimately terminates your coverage because you have not paid the entire amount of outstanding subscription charges before the end of the three-month grace period, any pended claims will be denied. Providers whose claims are denied by Health Net may bill you for payment. If you pay the entire amount of subscription charges due before the end of the three-month grace period, coverage that was suspended will be reinstated and Health Net will proceed to process pended claims for services rendered by health care providers in the second and third month of the three-month grace period.

PAYMENT OF SUBSCRIPTION CHARGES

The Subscriber is responsible for payment of Subscription Charges to Health Net.

INTRODUCTION TO HEALTH NET (SECTION 300)

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

In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this Plan for items or services that are Essential Health Benefits, if the items or services are provided by a participating provider that is also a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost sharing means Copayments, including coinsurance, and Deductibles. In addition, an American Indian or Alaskan Native who is enrolled in a zero cost sharing plan variation (because Your expected income has been deemed by the Exchange as being at or below 300% of the Federal Poverty Level), has no cost sharing obligation for Essential Health Benefits when items or services are provided by any participating provider.

The benefits described under this Plan Contract do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, Domestic Partner status or religion, and are not subject to any pre-existing condition or exclusion period.

Subsection-A

How to Obtain Care

When you enroll in this Plan, you must select a Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. Information on how to select a Primary Care Physician and a listing of the participating Primary Care Physicians in the Health Net Service Area, are available on the Health Net website at www.myhealthnetca.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Plan Contract and Evidence of Coverage and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group,

independent practice association or clinic or call the Customer Contact Center at 1-888-926-4988 to ensure that you can obtain the health care services that you need.

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 your prior coverage was an individual plan that was terminated due to the health plan or health insurer no longer offering your health plan and, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

- an Acute Condition;
- a Serious Chronic Condition not to exceed twelve months from the Member's Effective Date of coverage under this Plan;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);
- maternal mental health, not to exceed 12 months from the diagnosis or from the end of the 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 "Definitions," Section 1100.

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

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

Selecting a Primary Care Physician

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

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

Selecting a Contracting Physician Group

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

Some Physician Groups may decline to accept assignment of a Member whose home address is not close enough to the Physician Group to allow reasonable access to care. Please call the Customer Contact Center at the number shown on your Health Net I.D. Card if you need to request provider information or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.myhealthnetca.com.

Selecting a Participating Mental Health Professional

Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator), which contracts with Health Net to administer these benefits. 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 I.D. card. The Administrator will help you identify a Participating Mental Health Professional, a participating independent Physician or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for Mental Disorders and Chemical Dependency may require prior authorization by the Administrator in order to be covered. Please refer to the "Mental Disorders and Chemical Dependency" provision in "Covered Services and Supplies," Section 700 for a complete description of Mental Disorders and Chemical Dependency services and supplies, including those that require prior authorization by the Administrator.

Specialists and Referral Care

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

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

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

Standing Referral to Specialty Care for Medical and Surgical Services

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

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

Changing Physician Groups

You may transfer to another Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 600, of this Plan Contract.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible for any required Copayment amount for certain services, as described in "Schedule of Benefits and Copayments."

However, you are completely financially responsible for medical care that the Physician Group does not provide or authorize except for Medically Necessary care provided in a legitimate emergency. You are also financially responsible for care that this Plan does not cover.

Questions

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

Subsection-B

Timely Access to Care

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

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with Your Primary Care Physician

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

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

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Psychiatrist (Behavioral Health Physician) appointment:** within 10 business days of request for an appointment.
- **A therapist or social worker, non-Physician appointment:** within 10 business days of request for an appointment.

- **Urgent appointment for mental health visit:** within 48 hours of request for an appointment.
- **Non-life threatening behavioral health emergency:** within 6 hours of request for an appointment.

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

Scheduling Appointments with a Specialist for Medical and Surgical Services

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

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

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

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

Scheduling Appointments for Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

As a Health Net Member, when you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the Triage and/or Screening option to these services. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your

needs) who will be able to help you and answer your questions. As a Health Net Member, you have access to triage or screening service, 24 hours per day, 7 days per week.

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

Subsection-C

Emergency and Urgently Needed Care

What to do when you need medical care immediately

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

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

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

Except in an emergency or other urgent medical circumstances, the covered services of this plan must be performed by your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency) or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency).

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

Urgently Needed Care within a 30-mile radius of your Physician Group and all non-Emergency Care -- must be performed by your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency) or authorized by them in order to be covered. These services, if performed by others outside your Physician Group, will not be covered unless they are authorized by your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency).

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

It is critical that you contact your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency) as soon as you can after receiving emergency services from others outside your

Physician Group. Your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency) will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care. They will also advise you about how to obtain reimbursement for charges you may have paid.

Always present your Health Net ID Card to health care providers regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician Group (medical) or the Administrator (Mental Disorders and Chemical Dependency).

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

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

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

Definitions Related to Emergency and Urgently Needed Care

Please refer to "Definitions," Section 1100, for definitions of Emergency Care, Emergency Medical Condition, Psychiatric Emergency Medical Condition and Urgently Needed Care.

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a non-participating pharmacy, this Plan will pay you the retail cost of the drug less any required Deductible and Copayment shown in "Schedule of Benefits and Copayments," Section 400. You will have to pay for the Prescription Drug when it is dispensed.

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

Note

The Prescription Drugs portion of "Exclusions and Limitations," Section 800 and the requirements of the Essential Rx Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy.

Subsection-D

Pediatric Vision Services

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

Subsection-E

Pediatric Dental Services

Emergency dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that a person could reasonably expect that immediate dental care is needed.

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

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

SCHEDULE OF BENEFITS AND COPAYMENTS (SECTION 400)

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

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

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to, "Out-of-Pocket Maximum," Section 500 for more information.

In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this plan for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, as defined by Federal law. Cost sharing means copayments, including coinsurance, and deductibles.

Covered services for medical, Mental Disorders and Chemical Dependency conditions provided appropriately as Telehealth Services are covered on the same basis and to the same extent as covered services delivered in-person. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

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

	Copayment
Use of emergency room facility	$150
Emergency room physician	$0
Use of urgent care center (facility and professional services)	$15

Copayment Exceptions

- If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)
- For emergency care in an emergency room or urgent care center, you are required to pay only the copayment amounts required under this plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Ambulance Services

	Copayment
Ground ambulance	$150
Air ambulance	$150

Note:

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

Office Visits

	Copayment
Visit to Physician, Physician Assistant or Nurse Practitioner	$15
Specialist consultation	$30
Hearing examination for diagnosis or treatment	$15
Vision examination for diagnosis or treatment (ages 19 and older) by an Optometrist*	$15
Vision examination for diagnosis or treatment (ages 19 and older) by an Ophthalmologist*	$30
Physician visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$15
Specialist visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$30
Annual Physical Examination (1 per Calendar Year)**	Not Covered
Telehealth consultation through the Select Telehealth Services Provider***	$0

Notes:

- Self-referrals are allowed for obstetrician, gynecological services, and reproductive and sexual health care services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" and “Self-Referral for Reproductive and Sexual Health Care Services” portions of "Covered Services and Supplies," Section 700.)
- The office visit copayment applies to visits to your Primary Care Physician. The specialist consultation copayment applies to services that are performed by a Member Physician who is not your Primary Care Physician. When a specialist is your Primary Care Physician, the office visit copayment will apply to visits to that physician, except as noted below for certain Preventive Care Services. See “Primary Care Physician” in the “Definitions” section for information about the types of physicians you can choose as your Primary Care Physician.

* See “Pediatric Vision Services” for details regarding pediatric vision care services for ages younger than 19.

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

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

Preventive Care Services

	Copayment
Preventive Care Services	$0

Notes:

- 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), breast feeding support and supplies and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of "Covered Services and Supplies," Section 700 for details.
- If you receive any other covered services in addition to Preventive Care Services during the same visit, you will also pay the applicable Copayment for those services.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital	$0

Note:

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

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$30
Allergy serum	10%
Allergy injection services	$15
Immunizations for occupational purposes or foreign travel	Not covered
Injections (excluding injections for Infertility)	
Office based injectable medications (per dose)	10%

Notes:

- Immunizations that are part of Preventive Care Services are covered under "Preventive Care Services" in this section.
- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If you need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through our contracted specialty pharmacy vendor and bring it with you to the Physician's office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted specialty pharmacy vendor. Please refer to the "Tier 4 (Specialty Drugs)" portion of this "Schedule of Benefits and Copayments" section for the applicable Copayment.

Rehabilitation and Habilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Pulmonary therapy	$15
Cardiac therapy	$15
Habilitative therapy	$15

Notes:

- These services will be covered when Medically Necessary.
- Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain conditions as described under the heading "Rehabilitation Habilitation Therapy" of "Exclusions and Limitations," Section 800.

Care for Conditions of Pregnancy

	Copayment
Prenatal care and preconception visits	$0
Postnatal office visit*	$15
Newborn care office visit (birth through 30 days)*	$15
Physician visit to the mother or newborn at a Hospital**	$0
Professional Services for Normal delivery, including Cesarean section	$0
Complications of pregnancy	See note below
Normal delivery, including cesarean section	$0
Genetic testing of fetus	$15
Circumcision of newborn (birth through 30 days)***	
In an inpatient setting	$0
In a Physician's office or outpatient facility	$25

Notes:

- The above Copayments apply to the noted professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable inpatient and outpatient professional and facility Copayments. Look under the "Hospital Visits by Physician," "Other Professional Services," "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments that may apply.
- Applicable Copayment requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment will apply.

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

** One Copayment per visit.

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

Family Planning

	Copayment
Sterilization of female	$0
Sterilization of male*	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$25

Note:

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

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

Other Professional Services

	Copayment
Surgery	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$25
Assistance at surgery	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$25
Administration of anesthetics	
In an inpatient setting	$0
In a Physician’s office or outpatient facility	$25
Chemotherapy	10%
Radiation therapy	10%
Laboratory services	$15
Diagnostic imaging (including x-ray) services	$30
CT, SPECT, MRI, MUGA and PET	$75
Medical social services	$15
Patient education*	$0
Nuclear medicine (use of radioactive materials)	10%
Renal dialysis	10%
Organ, tissue, or stem cell transplant	$0
Infusion therapy in a home, outpatient or office setting**	10%

Notes:

- The above Copayments apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility Copayment. Look under the “Inpatient Hospital Services” and “Outpatient Facility Services” headings to determine any additional Copayments that may apply.
- Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry, also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

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

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

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers, face masks and tubing*	10%
Orthotics (such as bracing, supports and casts)	10%
Diabetic Equipment*	10%
Diabetic Footwear	10%
Prostheses (internal or external)**	10%
Blood or blood products, except for drugs used to treat hemophilia, including blood factors***	10%

Note:

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services” in this section. For additional information, please refer to the "Preventive Care Services" provision in “Covered Services and Supplies,” Section 700.

* Corrective footwear for the management and treatment of diabetes are covered under the “Diabetic Equipment” benefit as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see “Diabetic Equipment” in “Covered Services and Supplies,” Section 700.

** 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 considered self-injectable drugs and covered as a Tier 4 (Specialty Drug) under the Prescription Drug benefit.

Home Health Care Services

	Copayment
Home Health Care Services	$20 per visit

Limitation:

100 visits maximum per Calendar Year.

Hospice Services

	Copayment
Hospice care	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi private room or special care unit including ancillary (additional) services	$250 per day up to 5 days

Notes:

- The above Copayments apply to facility services only. Care that is rendered in a Hospital is also subject to the professional services Copayments. Look under the "Hospital Visits by Physician," "Care for Conditions of Pregnancy" and "Other Professional Services" headings to determine any additional Copayments that may apply.
- The above Copayment is applicable for each day of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Copayment for inpatient Hospital Services for the newborn patient will apply.
- No additional Copayment after the first 5 days of a continuous inpatient Hospital stay.

Outpatient Facility Services

	Copayment
Outpatient surgery facility (surgery performed in a hospital outpatient setting or Outpatient Surgical Center)	$100
Outpatient facility services (other than surgery)	10%

Notes:

- The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments. Look under the "Care for Conditions of Pregnancy," "Family Planning" and "Other Professional Services" headings to determine any additional Copayments that may apply.
- Other professional services performed in the outpatient department of a hospital, such as a visit to a Physician (office visit), lab and X-ray services, physical therapy, etc. are subject to the same Copayment which is required when these services are performed at your Physician's office. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other professional services to determine any additional Copayments that may apply.

- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the ”Preventive Care Services” section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment applicable for outpatient facility services (other than surgery).
- Use of a Hospital emergency room appears in the first item at the beginning of this section.

Skilled Nursing Facility Services

	Copayment
Room and board in a semiprivate room with ancillary (additional) services	$150 per day up to 5 days

Note:

- No additional Copayment after the first 5 days of a continuous Skilled Nursing Facility stay.

Mental Disorders and Chemical Dependency Benefits

Severe Mental Illness or Serious Emotional Disturbances of a Child

	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15
Outpatient group therapy session	$7.50
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$0
Participating Mental Health Professional visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Administrator)	$15
Participating Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0
Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center	$250 per day up to 5 day

Other Mental Disorders

	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15
Outpatient group therapy session	$7.50
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient	

procedures, intensive outpatient care program, day treatment and partial hospitalization)	$0
Participating Mental Health Professional visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Administrator)	$15
Participating Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0
Inpatient Services at a Hospital, Behavioral Health Facility or Residential Treatment Center	$250 per day up to 5 days

Chemical Dependency

	Copayment
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$15
Outpatient group therapy session	$7.50
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization)	$0
Participating Mental Health Professional visit to a Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by the Administrator)	$15
Participating Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0
Inpatient Services at a Hospital, Behavioral Health Facility or Residential Treatment Center	$250 per day up to 5 days
Detoxification	$250 per day up to 5 days

Notes:

- Each group therapy session counts as one half of a private office visit for each Member participating in the session.
- The applicable Copayment for outpatient services is required for each visit.

Exceptions

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

Prescription Drugs

Refer to the **Note** below for clarification of your financial responsibility regarding Copayment.

	Copayment

Retail Pharmacy (up to a 30 day supply)

Tier 1 Drugs (most generic drugs and low cost preferred brand name drugs. when listed in the Essential Rx Drug List) $5

Tier 2 Drugs (Non-preferred Generic and preferred Brand Name Drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Essential Rx Drug List) $15

Tier 3 Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 Drugs in the Essential Rx Drug List, drugs indicated as "NF," if approved, or drugs not listed in the Essential Rx Drug List) $25

Preventive drugs and women's contraceptives $0

Tier 4 (Specialty Drugs) (up to a 30 day supply)

Tier 4 (Specialty Drugs) (may be required through a specialty pharmacy vendor. Includes Specialty Drugs that are not listed on the Essential Rx Drug List and that are covered as an exception.) ..... 10% up to $250 per script

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

Tier 1 Drugs (most generic drugs and low cost preferred brand name drugs when listed in the Essential Rx Drug List) $10

Tier 2 Drugs (non-preferred generic and preferred brand name drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Essential Rx Drug List) $30

Tier 3 Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), drugs listed as Tier 3 Drugs in the Essential Rx Drug List, drugs indicated as "NF," if approved, or drugs not listed in the Essential Rx Drug List) $50

Preventive drugs and women's contraceptives $0

Notes:

- Up to a 90-day supply of Maintenance Drugs may be purchased at retail pharmacies within Riverside and Sonoma counties. There will be a Copayment for each 30-day supply or portion of a 30 day supply.
- **Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.**
- For information about Health Net's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.
- You will be charged a Copayment for each Prescription Drug Order.

- Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the “Prescription Drugs” portion of the “Covered Services and Supplies” and the “Exclusions and Limitations” sections.
- Percentage Copayments will be based on Health Net’s contracted pharmacy rate.
- Regardless of prescription drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name drugs, including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered Brand Name Drugs are subject to the applicable Copayment for Tier 2, Tier 3 or Tier 4 (Specialty Drugs) prescription drugs.

Prior Authorization:

Prior Authorization may be required. Refer to the "Prescription Drugs" portion of "Covered Services and Supplies" Section 700 for a description of Prior Authorization requirements or visit our website at www.myhealthnetca.com to obtain a list of drugs that require Prior Authorization.

Copayment exceptions:

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

Preventive Drugs and Women’s Contraceptives:

Preventive drugs, including smoking cessation drugs, and women’s contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Covered preventive drugs include over-the-counter drugs and Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Forces A and B recommendations, including smoking cessation drugs. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Please see the "Preventive Drugs and Women’s Contraceptives" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 700, for additional details.

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.

Mail Order:

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

Diabetic Supplies:

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

Tier 4 (Specialty Drugs)

Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes biologics and drugs that the FDA or drug manufacturer requires to be distributed through a Specialty Pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Essential Rx Drug List with "SP", require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 (Specialty) Drugs are not available through mail order.

Pediatric Vision Services

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

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

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

Professional Services

	Copayment
Routine eye examination with dilation	$0*
Examination for Contact Lenses	
Standard contact lens fit and follow-up	up to $55
Premium contact lens fit and follow-up	10% off retail

Limitation:

* In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every calendar year.

Notes:

- Examination for contact lenses is in addition to the Member's vision examination. There is no additional copayment for contact lens follow-up visit after the initial fitting exam.
- **Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one time use benefits. No remaining balance.**
- Standard contact lens includes soft, spherical and daily wear contact lenses.
- Premium contact lens includes toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable contact lenses.

Materials (includes frames and lenses)

	Copayment
Provider selected Frames (one every 12 months)	$0
Standard Plastic Eyeglass Lenses (one pair every 12 months)	$0
• Single vision, bifocal, trifocal, lenticular	
• Glass or plastic	
Optional Lenses and Treatments including:	$0
• UV Treatment	
• Tint (Fashion & Gradient & Glass-Grey)	
• Standard Plastic Scratch Coating	
• Standard Polycarbonate	
• Photochromatic / Transitions Plastic	
• Standard Anti-Reflective Coating	
• Polarized	
• Standard Progressive Lens	
• Hi-Index Lenses	
• Blended segment Lenses	
• Intermediate vision Lenses	
• Select or ultra-progressive lenses	
Premium Progressive Lenses	$0
Provider selected Contact Lenses (In lieu of eyeglass lenses)	$0
• Extended Wear Disposables: Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	
• Daily Wear/Disposables: Up to 3 month supply of daily disposables, single vision spherical contact lenses	
• Conventional: 1 pair from selection of provider designated contact lenses	
• Medically Necessary*	

* Contact Lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

- High Ametropia exceeding -10D or +10D in meridian powers
- Anisometropia of 3D in meridian powers
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses

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

Medically Necessary Contact Lenses:

Coverage of Medically Necessary contact lenses is subject to Medical Necessity and all applicable exclusions and limitations. See “Pediatric Vision Services” portion of “Exclusions and Limitations” for details of limitations.

Pediatric Dental Services

Except as otherwise provided in the “Pediatric Dental Services” portion of “Covered Services and Supplies,” and “Pediatric Dental Services” portion of “Introduction to Health Net,” all of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. Refer to the “Pediatric Dental Services” portion of “Exclusions and Limitations” for limitations on covered pediatric dental services.

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

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

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

Administration of these pediatric dental plan designs comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for pediatric dental services.

Code	Service	Member Copayment
Diagnostic		
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge

Code	Service	Member Copayment
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) up to six times in a 3 month period and up to a maximum of 12 in a 12 month period	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays Intraoral - complete series (including bitewings) limited to once per provider every 36 months	No Charge
D0220	X-rays Intraoral - periapical first film limited to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.	No Charge
D0230	X-rays Intraoral - periapical each additional film limited to a maximum of 20 periapicals in a 12 month period	No Charge
D0240	X-rays Intraoral - occlusal film limited to 2 in a 6 month period	No Charge
D0250	Extraoral, 2D projection radiographic image created using a stationary radiation source, and detector - first film	No Charge
D0251	Extraoral posterior dental radiographic image	No Charge
D0270	X-rays Bitewing - single film limited to once per date of service	No Charge
D0272	X-rays Bitewings - two films limited to once every 6 months	No Charge
D0273	X-rays Bitewings - three films	No Charge
D0274	X-rays Bitewings - four films - limited to once every 6 months	No Charge
D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge

Code	Service	Member Copayment
D0320	Temporomandibular joint arthrogram, including injection limited to a maximum of 3 per date of service	No Charge
D0322	Tomographic survey limited to twice in a 12 month period	No Charge
D0330	Panoramic film limited to once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery)	No Charge
D0340	2D Cephalometric radiographic image limited to twice in a 12 month period per provider	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0351	3D photographic image	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Office visit fee - per visit (Unspecified diagnostic procedure, by report)	No Charge
Preventive		
D1110	Prophylaxis - adult limited to once in a 12 month period	No Charge
D1120	Prophylaxis - child limited to once in a 6 month period	No Charge
D1206	Topical fluoride varnish limited to once in a 6 month period	No Charge
D1208	Topical application of fluoride excluding varnish limited to once in a 6 month period	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge

Code	Service	Member Copayment
D1351	Sealant - per tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth limited to first, second and third permanent molars that occupy the second molar position	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	Interim caries arresting medicament application - per tooth	No Charge
D1510	Space maintainer - fixed - unilateral limited to once per quadrant	No Charge
D1516	Space maintainer - fixed – bilateral, maxillary	No Charge
D1517	Space maintainer - fixed – bilateral, mandibular	No Charge
D1520	Space maintainer - removable - unilateral limited to once per quadrant	No Charge
D1526	Space maintainer - removable – bilateral, maxillary	No Charge
D1527	Space maintainer - removable – bilateral, mandibular	No Charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No Charge
D1553	Re-cement or re-bond bilateral space maintainer – per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Charge
D1557	Removal of fixed bilateral space maintainer - maxillary	No Charge
D1558	Removal of fixed bilateral space maintainer - mandibular	No Charge
D1575	Distal shoe space maintainer - fixed - unilateral – per quadrant	No Charge
Restorative		
D2140	Amalgam - one surface, primary limited to once in a 12 month period	$25
D2140	Amalgam - one surface, permanent limited to once in a 36 month period	$25
D2150	Amalgam - two surfaces, primary limited to once in a 12 month period	$30

Code	Service	Member Copayment
D2150	Amalgam - two surfaces, permanent limited to once in a 36 month period	$30
D2160	Amalgam - three surfaces, primary limited to once in a 12 month period	$40
D2160	Amalgam - three surfaces, permanent limited to once in a 36 month period	$40
D2161	Amalgam - four or more surfaces, primary limited to once in a 12 month period	$45
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36 month period	$45
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12 month period	$30
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36 month period	$30
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12 month period	$45
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36 month period	$45
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12 month period	$55
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36 month period	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) primary limited to once in a 12 month period	$60
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior) permanent limited to once in a 36 month period	$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12 month period	$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36 month period	$50
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12 month period	$30
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36 month period	$30

Code	Service	Member Copayment
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12 month period	$40
D2392	Resin-based composite - two surfaces, posterior; permanent limited to once in a 36 month period	$40
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12 month period	$50
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36 month period	$50
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12 month period	$70
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36 month period	$70
D2710	Crown - Resin-based composite (indirect) limited to once in a 5 year period	$140
D2712	Crown - ¾ resin-based composite (indirect) limited to once in a 5 year period	$190
D2721	Crown - Resin with predominantly base metal limited to once in a 5 year period	$300
D2740	Crown - porcelain/ceramic substrate limited to once in a 5 year period	$300
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5 year period	$310
D2791	Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12 month period	$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	$25
D2920	Recement or re-bond crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12 month period	$95

Code	Service	Member Copayment
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12 month period	$65
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36 month period	$75
D2932	Prefabricated Resin Crown, primary limited to once in a 12 month period	$75
D2932	Prefabricated Resin Crown, permanent limited to once in a 36 month period	$75
D2933	Prefabricated Stainless steel crown with resin window, primary limited to one in a 12 month period	$80
D2933	Prefabricated Stainless steel crown with resin window, permanent limited to once in a 36 month period	$80
D2940	Protective restoration limited to once per tooth in a 12 month period	$25
D2941	Interim therapeutic restoration - primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins when required	$20
D2951	Pin retention - per tooth, in addition to restoration	$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	$100
D2953	Each additional indirectly fabricated post - same tooth	$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to construct new crown under existing partial dental framework	$35
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.	$50
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	$20

Code	Service	Member Copayment
D3120	Pulp cap - indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	$40
D3221	Pupal debridement primary and permanent teeth	$40
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	$60
D3230	Pulpal therapy (resorbable filing) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3240	Pulpal therapy (resorbable filing) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	$55
D3310	Endodontic (Root canal) therapy, Anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$195
D3320	Endodontic (Root canal) therapy, Bicuspid (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$235
D3330	Endodontic (Root canal) therapy, Molar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy - anterior	$240
D3347	Retreatment of previous root canal therapy - bicuspid	$295
D3348	Retreatment of previous root canal therapy - molar	$365
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	$85
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth	$45
D3410	Apicoectomy - anterior	$240

Code	Service	Member Copayment
D3421	Apicoectomy - bicuspid (first root)	$250
D3425	Apicoectomy - molar (first root)	$275
D3426	Apicoectomy (each additional root)	$110
D3427	Periradicular surgery without apicoectomy	$160
D3430	Retrograde filling - per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$50
D4249	Clinical crown lengthening - hard tissue	$165
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth spaces per quadrant - once per quadrant every 36 months	$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10

Code	Service	Member Copayment
D4910	Periodontal maintenance limited to once in a calendar quarter	$30
D4920	Unscheduled dressing change (by someone other than treating dentist). Once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).	$15
D4999	Unspecified periodontal procedure, by report	$350
Prosthodontics, removable		
D5110	Complete denture - maxillary limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5120	Complete denture - mandibular limited to once in a 5 year period from a previous complete, immediate or overdenture- complete denture	$300
D5130	Immediate denture - maxillary	$300
D5140	Immediate denture - mandibular	$300
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5 year period	$335
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330

Code	Service	Member Copayment
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12 month period	$20
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12 month period	$20
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12 month period	$20
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12 month period	$20
D5511	Repair broken complete denture base, mandibular	$40
D5512	Repair broken complete denture base, maxillary	$40
D5520	Replace missing or broken teeth - complete denture (each tooth) limited to a maximum of four, per arch, per date of service; twice per arch in a 12 month period	$40
D5611	Repair resin denture base, mandibular	$40
D5612	Repair resin denture base, maxillary	$40
D5621	Repair cast framework, mandibular	$40
D5622	Repair cast framework, maxillary	$40
D5630	Repair or replace broken retentive/clasping materials- per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$50
D5640	Replace broken teeth - per tooth - limited to maximum of four, per arch, per date of service; twice per arch in a 12 month period	$35
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of service; once per tooth	$35
D5660	Add clasp to existing partial denture - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12 month period	$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12 month period	$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12 month period	$60

Code	Service	Member Copayment
D5740	Reline maxillary partial denture (chairside) limited to once in a 12 month period	$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12 month period	$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12 month period	$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12 month period	$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12 month period	$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12 month period	$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36 month period	$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture - complete maxillary	$300
D5864	Overdenture - partial maxillary	$300
D5865	Overdenture - complete mandibular	$300
D5866	Overdenture - partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350

Code	Service	Member Copayment
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification limited to twice in a 12 month period	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12 month period	$145
D5960	Speech aid prosthesis, modification limited to twice in a 12 month period	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85

Code	Service	Member Copayment
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Vesiculobullous disease medicament carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implant	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported crown (porcelain fused to high noble alloys)	$335

Code	Service	Member Copayment
D6067	Implant supported crown (high noble alloys)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$350
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6082	Implant supported crown - porcelain fused to predominantly bass alloys	$335
D6083	Implant supported crown - porcelain fused to noble alloys	$335
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335
D6085	Provisional implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown - noble alloys	$340
D6088	Implant supported crown - titanium and titanium alloys	$340
D6090	Repair implant supported prosthesis, by report	$65

Code	Service	Member Copayment
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown - titanium and titanium alloys	$295
D6095	Repair implant abutment, by report	$65
D6096	Removal of broken implant retaining screw	$60
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330

Code	Service	Member Copayment
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD - noble alloys	$350
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, fixed		
D6211	Pontic - cast predominantly base metal limited to once in a 5 year period	$300
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6245	Pontic - porcelain/ceramic limited to once in a 5 year period	$300
D6251	Pontic - resin with predominantly base metal limited to once in a 5 year period	$300
D6721	Retainer Crown - resin predominantly base metal - denture limited to once in a 5 year period	$300
D6740	Retainer Crown - porcelain/ceramic limited to once in a 5 year period	$300
D6751	Retainer Crown - porcelain fused to predominantly base metal limited to once in a 5 year period	$300
D6781	Retainer Crown - ¾ cast predominantly base metal limited to once in a 5 year period	$300
D6783	Retainer Crown - ¾ porcelain/ceramic limited to once in a 5 year period	$300
D6784	Retainer Crown - ¾ titanium and titanium alloys	$300
D6791	Retainer Crown - full cast predominantly base metal limited to once in a 5 year period	$300
D6930	Recement or re-bond fixed partial denture	$40

Code	Service	Member Copayment
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
Oral Maxillofacial Prosthetics		
D7111	Extraction, coronal remnants - deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$120
D7220	Removal of impacted tooth - soft tissue	$95
D7230	Removal of impacted tooth - partially bony	$145
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Removal of residual tooth roots (cutting procedure)	$80
D7260	Oroantral fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	$185
D7280	Exposure of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	$180
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	$110
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	$185

Code	Service	Member Copayment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	$80
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	$85
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	$65
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) limited to once in a 5 year period per arch	$350
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	$350
D7410	Excision of benign lesion up 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330

Code	Service	Member Copayment
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	$140
D7472	Removal of torus palatinus limited to once in a patient's lifetime	$145
D7473	Removal of torus mandibularis limited to once per quadrant	$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	$70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	$70
D7520	Incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone limited to once per quadrant per date of service	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250
D7630	Mandible - open reduction (teeth immobilized, if present)	$350

Code	Service	Member Copayment
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch - open reduction	$350
D7660	Malar and/or zygomatic arch - closed reduction	$350
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170
D7671	Alveolus - open reduction, may include stabilization of teeth	$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla - open reduction	$110
D7720	Maxilla - closed reduction	$180
D7730	Mandible - open reduction	$350
D7740	Mandible - closed reduction	$290
D7750	Malar and/or zygomatic arch - open reduction	$220
D7760	Malar and/or zygomatic arch - closed reduction	$350
D7770	Alveolus - open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrotomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90

Code	Service	Member Copayment
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy - diagnosis, with or without biopsy	$350
D7873	Arthroscopy - lavage and lysis of adhesions	$350
D7874	Arthroscopy - disc repositioning and stabilization	$350
D7875	Arthroscopy - synovectomy	$350
D7876	Arthroscopy - discectomy	$350
D7877	Arthroscopy - debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture - up to 5 cm	$55
D7912	Complicated suture - greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
D7940	Osteoplasty - for orthognathic deformities	$160
D7941	Osteotomy - mandibular rami	$350
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy - segmented or subapical	$275
D7945	Osteotomy - body of mandible	$350
D7946	LeFort I (maxilla - total)	$350
D7947	LeFort I (maxilla - segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350
D7949	LeFort II or LeFort III - with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290

Code	Service	Member Copayment
D7952	Sinus augmentation via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure not incidental to another procedure limited to once per arch per date of service	$120
D7963	Frenuloplasty limited to once per arch per date of service	$120
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	$175
D7971	Excision of pericoronal gingiva	$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	$100
D7979	Non-surgical Sialolithotomy	$155
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft - mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	$60
D7999	Unspecified oral surgery procedure, by report	$350
Orthodontics		
	Medically Necessary Banded Case (The copayment applies to a Member’s course of treatment as long as that Member remains enrolled in this plan.)	$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	

Code	Service	Member Copayment
D8670	Periodic orthodontic treatment visit	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8696	Repair of orthodontic appliance - maxillary	
D8697	Repair of orthodontic appliance - mandibular	
D8698	Recement or re-bond fixed retainer - maxillary	
D8699	Recement or re-bond fixed retainer - mandibular	
D8701	Repair of fixed retainer, includes reattachment - maxillary	
D8702	Repair of fixed retainer, includes reattachment - mandibular	
D8703	Replacement of lost or broken retainer - maxillary	
D8704	Replacement of lost or broken retainer - mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9222	Deep sedation/general anesthesia - first 15 minutes	$45
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60

Code	Service	Member Copayment
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$60
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	$0
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament limited to once in a 12 month period; permanent teeth only	$20
D9930	Treatment of complications - post surgery, unusual circumstances, by report limited to once per date of service	$35
D9950	Occlusion analysis - mounted case limited to once in a 12 month period	$120
D9951	Occlusal adjustment - limited. Limited to once in a 12 month period per quadrant	$45
D9952	Occlusal adjustment - complete. Limited to once in a 12 month period following occlusion analysis- mounted case (D9950)	$210
D9997	Dental case management - patients with special health care needs	$0
D9999	Unspecified adjunctive procedure, by report	$0

Dental codes from “Current Dental Terminology© American Dental Association.”

Acupuncture Services

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

Office Visits

	Copayment
New patient examination	$15
Each subsequent visit	$15
Re-examination visit	$15
Second opinion	$15

Note:

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

Limitation:

Acupuncture services, typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, are covered when Medically Necessary.

OUT-OF-POCKET MAXIMUM (SECTION 500)

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

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

The OOPM amounts for this Plan are:

One Member $4,500
Family $9,000

Exceptions to OOPM

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

How the OOPM Works

Here's how the OOPM works:

- If an individual Member pays amounts for covered services and supplies in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services and supplies paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services. (NOTE: In order for the Family Out-of-Pocket Maximum to apply, all Family Members must be enrolled under a single Subscriber. Family Members enrolled as separate Subscribers are each subject to the One Member Out-of-Pocket Maximum.)
- 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 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 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 (SECTION 600)

Subsection-A

Who is Eligible and How to Enroll for Coverage

Health Net establishes the conditions of eligibility that must be met in order to be eligible for coverage under this health plan. In order to enroll in and receive coverage under this plan, Subscriber and each of the Subscriber's Family Members that apply for enrollment must: (a) live in the Health Net Service Area; (b) be a citizen or national of the United States or an alien lawfully present in the United States; (c) not be incarcerated; and (d) apply for enrollment during an open enrollment period or during a special enrollment period as defined below under "Special Enrollment Periods." The following persons are not eligible for coverage under this plan: (a) persons eligible for enrollment in a group plan with minimum essential coverage; (b) persons age 65 and older and eligible for Medicare benefits; (c) are incarcerated; and (d) persons eligible for Medi-Cal or other applicable state or federal programs. If you have end-stage renal disease and are eligible for Medicare, you remain eligible for enrollment in this plan until you are enrolled in Medicare. The Notice of Acceptance indicates the names of applicants who have been accepted for enrollment, the effective date thereof, the plan selected and the monthly subscription charge.

Subscribers who enroll in this plan may also apply to enroll Family Members who satisfy the eligibility requirements for enrollment. The following types of dependents describe those Family Members who may apply for enrollment in this plan:

- Spouse: The Subscriber's lawful spouse, as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined in "Definitions," Section 1100.)
- Children: The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).

Age Limit for Children

Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age). An enrolled Dependent child who reaches age 26 during a calendar year may remain enrolled as a dependent until the end of that calendar year. The dependent coverage shall end on the last day of the calendar year during which the Dependent child become ineligible.

Special Enrollment Periods

In addition to the Open Enrollment period, you are eligible to enroll in this plan within 60 days of certain events, including but not limited to the following:

- Gained, lost or changed dependent status due to marriage, domestic partnership, divorce, legal separation, dissolution of domestic partnership, birth, adoption, placement for adoption, coverage mandated by a valid state or federal court order, or assumption of a parent-child relationship(see "Newly Acquired Dependents" section below);

- Were mandated to be covered as a dependent due to a valid state or federal court order;
- Demonstrate that you had a material provision of your health coverage contract substantially violated by your health coverage issuer;
- Were receiving services under another health benefit plan from a contracting provider, who is no longer participates in that health plan, for any of the following conditions: (a) an acute or serious condition; (b) a terminal illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contracts termination date or the effective date of coverage for a newly covered member;
- Demonstrate to Covered California that you did not enroll in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage;
- Are a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code;
- Were not allowed to enroll in a plan through Covered California due to the intentional, inadvertent or erroneous actions of the Exchange.
- Gain or maintain status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, or are or become a dependent of an Indian, and are enrolled in or are enrolling on the same application as the Indian (you can change from one plan to another one time per month).
- It is determined by Covered California on a case-by-case basis that the qualified individual or enrollee, or his or her Dependents, was not enrolled as a result of misconduct on the part of a non-Covered California entity providing enrollment assistance or conducting enrollment activities.
- It is demonstrated to Covered California, in accordance with guidelines issued by the Department of Health and Human Services, that the individual or enrollee meets other exceptional circumstances as Covered California may provide.
- Are a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
- Apply for coverage through Covered California during the annual open enrollment period or due to a qualifying event and are assessed by Covered California as potentially eligible for Medi-Cal, and are determined ineligible for such coverage either after open enrollment has ended or more than 60 days after the qualifying event.
- Apply for coverage with Medi-Cal during the annual open enrollment period and are determined ineligible for such coverage after open enrollment has ended.
- Adequately demonstrate to Covered California that a material error related to plan benefits, service area or premium influenced your decision to purchase coverage through Covered California.

- Provide satisfactory documentary evidence to Covered California to verify eligibility following termination of enrollment due to failure to verify status within the required time period or are under 100 percent of the Federal poverty level and did not enroll while waiting for the United States Department of Health and Human Services to verify citizenship, status as a national or lawful presence.
- Apply for coverage between October 15 and October 31, with an effective date of coverage of January 1, or between December 16 and January 31, with an effective date no later than February 1.

For the following, you are eligible to enroll 60 days before and 60 days after the event:

- Lost coverage in a plan with minimum essential coverage (coverage becomes effective the first of the following month after loss of coverage), not including voluntary termination, loss due to non-payment of premiums or situations allowing for a rescission (fraud or intentional misrepresentation of material fact);
- Were enrolled in any non-Calendar Year plan that expired or will expire, even if you or your Dependent had the option to renew the plan. The date of the loss of coverage shall be the date of the expiration of the non-Calendar Year policy;
- Lost medically needy coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Lost pregnancy-related coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium);
- Gained access to new health benefit plans as a result of a permanent move;
- Were released from incarceration;
- Newly become a citizen or national of the United States or an alien lawfully present in the United States;
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a health benefit plan. Covered California must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for their employer's upcoming plan year to access this special enrollment period prior to the end of the coverage through the eligible employer-sponsored plan.

Disabled Child

Children who reach age 26 are eligible to apply to continue enrollment as a Dependent for 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 applying to enroll a disabled child for new coverage as a Dependent, 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.

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

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

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

Legal Separation or Final Decree of Dissolution of Marriage or Domestic Partnership or Annulment

On midnight of the last day of the month in which legal separation occurs or entry of the final decree of dissolution of marriage or Domestic Partnership or annulment occurs, a spouse shall cease to be an eligible Family Member. Children of the spouse who are not also the natural or legally adopted children of the Subscriber shall cease to be eligible Family Members at the same time.

Change in Eligibility

You must notify Covered California of changes that will affect your eligibility, including no longer residing in the Health Net Service Area. You should direct any such correspondence to Covered California at: Covered CA, P.O. Box 989725, West Sacramento, CA 95798.

Subsection-B

Special Enrollment Periods for 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 apply to enroll your new spouse (and your spouse's eligible children) within 60 days of the date of marriage by submitting a new Enrollment Application to Covered California. If your spouse is accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance for the new enrollee.

Domestic Partner: If you are the Subscriber and you enter into a domestic partnership while you are covered by this Plan, you may apply to enroll your new Domestic Partner (and his or her eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State by submitting a new Enrollment Application to Covered California. If your Domestic Partner is accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance for the new enrollee.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child within 31 days of birth by submitting an Enrollment Application to Covered California and paying any applicable subscription charges. If you do not enroll the child within 31 days of birth, your child will be eligible to enroll under a special enrollment period within 60 days of birth.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group. If the mother is not enrolled, the child will be automatically assigned to the

Subscriber's Physician Group. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

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

Coverage begins automatically and will continue for 30 days from the date of eligibility. The child will be assigned to the Subscriber's Physician Group. You must enroll the child within 31 days for coverage to continue beyond the first 30 days by submitting an Enrollment Application to Covered California and paying any applicable subscription charges. If you do not enroll the child within 31 days of adoption/placement, your child will be eligible to enroll under a special enrollment period within 60 days of adoption placement. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Court Ordered Dependent: If the Subscriber is required by a court order, as defined by applicable state or federal law, to provide coverage for a minor child through Health Net, the Subscriber must request permission from the Covered California for the child to enroll. Once Covered California approves the child's enrollment, Health Net will provide coverage in accordance with the requirements of the court order. The child's coverage under this provision will not extend beyond any Dependent age limit. Coverage will begin on the effective date of the court order, but coverage is not automatic. You must enroll the child within 60 days of the effective date of the court order by submitting an Enrollment Application to Covered California and paying any applicable subscription charges. The child will be assigned to the Subscriber's Physician Group. Coverage will begin on the first day of the month after Health Net receives the enrollment request. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Physician Group" portion of this section.

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. You must enroll the child within 60 days of the effective date of the court order by submitting an Enrollment Application to Covered California and paying any applicable subscription charges. The child will be assigned to the Subscriber's Physician Group. Coverage will begin on the first day of the month after Health Net receives the enrollment request. You must enroll the child by submitting a Newborn Addition Form to Health Net and paying any applicable Subscription Charges. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Physician Group" portion of this section.

Subsection-C

Special Reinstatement Rule for Reservists Returning from Active Duty

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

Please notify Covered California when you return from active duty if you want to reinstate your coverage under this Plan.

Subsection-D

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Physician Group" portion of "Introduction to Health Net," Section 300, each person must select a Physician Group close enough to his or her residence to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID card if you have questions involving reasonable access to care.

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

- The Member moves to a new address (notify Health Net within 30 days of the change).
- Determined necessary by Health Net.
- The Member exercises the once-a-month transfer option.

  Exceptions

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

Effective Date of Transfer

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

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

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

Subsection-E

Renewal Provisions

Subject to the termination provisions described below, coverage will remain in effect for each month subscription charges are received and accepted by Health Net.

Subsection-F

Re-enrollment

If you terminate coverage for yourself or any of your Family Members, you may apply for re-enrollment.

Subsection-G

Termination for Cause

You may terminate this Plan Contract by notifying Covered California or Health Net at least 14 days before the date that you request that the Plan Contract terminate. The Plan Contract will end at 12:01 a.m. 14 days after you notify Covered California or Health Net, on a later date that you request, or on an earlier date that you request if Health Net agrees to the earlier date. If the terms of this Plan Contract are altered by Health Net, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Health Net may terminate this Plan Contract together with all like Plan Contracts by giving 90 days' written notice to the Subscriber and the California Department of Managed Health Care.

Health Net may individually terminate or not renew this Plan Contract for the following reasons or under the following circumstances:

- Failure of the Subscriber to pay any subscription charges when due in the manner specified in "Subscription Charges," Section 200. See "Subscription Charges", Section 200 for additional information regarding termination resulting from failure of the Subscriber to pay any Subscription Charges.
- If you commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed. Some examples include:
  a. Misrepresenting eligibility information about you or a Dependent
  b. Presenting an invalid prescription or physician order
  c. Misusing a Health Net Member I.D. Card (or letting someone else use it)
- Termination of this Plan Contract for good cause. Termination will effective as noted below:
  a. Except for no longer residing in the Service Area, when the Subscriber ceases to be eligible according to any other eligibility provisions of this health plan, coverage will be terminated for Subscriber and any enrolled Family Members effective on midnight of the last day of the month for which loss of eligibility occurs. See "Who is Eligible and How to Enroll" earlier in this section for eligibility provisions.
  b. Except for no longer residing in the Service Area, when the Family Member ceases to be eligible according to any other eligibility provisions of this health plan, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.

c. When the Subscriber or Family Member ceases to reside in the Service area, coverage will be terminated 30 days from the date the letter is mailed.

If a Member's coverage is terminated under this health plan by Health Net for any reason noted above other than failure to pay subscription charges, 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 and (c) your right to submit a grievance. 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.

If coverage is terminated for failure to pay subscription charges when due, or for committing any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, you may lose the right to re-enroll in Health Net in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

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

Members are responsible for payment for any services received after termination of this Plan Contract at the provider's prevailing, non-Member rates. This is also applicable to Members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of this Plan Contract.

Subsection-H

Rescission or Cancellation of Coverage for Fraud or Intentional Misrepresentation of Material Fact

WHEN HEALTH NET CAN RESCIND OR CANCEL A PLAN CONTRACT: Within the first 24 months of coverage, Health Net may rescind this Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

Health Net may cancel a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the Plan Contract.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

Cancellation of a Plan Contract

If this Plan Contract is cancelled, you will be sent a cancellation or nonrenewal notice 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 and (c) your right to submit a grievance. 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.

Rescission of a Plan Contract

If this Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under this Plan Contract.

By signing the enrollment application, you represented that all responses were true, complete and accurate, and that the enrollment application would become part of the Plan Contract between Health Net and you. By signing the enrollment application you further agreed to comply with the terms of this Plan Contract.

If this Plan Contract is rescinded, you will be sent a rescission notice at least 30 days prior to the rescission 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. Once coverage is rescinded, 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.

If this Plan Contract is rescinded:

1. Health Net may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received;
2. Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you and may recover from you any amounts paid under the Plan Contract from the original date of coverage; and
3. Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If you believe Health Net has improperly rescinded your coverage, you may file a grievance to appeal the decision. See the “Grievance, Appeals, Independent Medical Review and Arbitration" portion of the "General Provisions" section of this Plan Contract and Evidence of Coverage.

COVERED SERVICES AND SUPPLIES (SECTION 700)

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

Any covered service or supply may require a Copayment, be subject to a Deductible or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 400, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 800, before obtaining care.

Subsection-A

Medical Services and Supplies

Office Visits

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

CVS MinuteClinic Services

CVS MinuteClinic visits for Preventive Care Services and for the diagnosis and evaluation of minor illnesses or injuries are covered as follows.

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

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

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

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

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

You will receive a written visit summary at the conclusion of each CVS MinuteClinic visit. With your permission, summaries of your CVS MinuteClinic visit, regardless of visit type, are sent to your Primary

Care Physician. If you require a non-emergent referral to a Specialist, you will be referred back to your Primary Care Physician for coordination of such care.

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

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

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

Preventive Care Services

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

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

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

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

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, prostate and cervical cancer screening, screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays

- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for Human Papillomavirus (HPV) for children and adults through age 45 as recommended by Your Physician
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Human immunodeficiency virus (HIV) screening and counseling
- Well-woman visits

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

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by Your Physician. 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.

Preventive Care Services are covered as shown in "Schedule of Benefits and Copayments," Section 400.

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment are covered. Preventive vision and hearing screening are covered as Preventive Care Services as shown in "Schedule of Benefits and Copayments" Section 400. See the “Pediatric Vision Services” portion of the “Schedule of Benefits and Copayments” for information regarding vision examinations for children under 19 years of age.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 400. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 400.

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

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

Self-Referral for Reproductive and Sexual Health Care Services

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 400. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 400.

Immunizations and Injections

The Plan covers immunizations and injections (including infusion therapy when administered by a health care professional in the office setting), professional services to inject the medications and the medications that are injected. This includes allergy serum. Preventive Care Services are covered under the "Preventive Care Services" heading as shown in this section, and in "Schedule of Benefits and Copayments," Section 400.

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

You will be charged the appropriate Copayment as shown in "Schedule of Benefits and Copayments," Section 400.

Surgical Services

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

Gender Reassignment Surgery

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

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Home Visit

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

Rehabilitation Therapy

Rehabilitation therapy services (physical, speech and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 800.

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 his or her license, to treat physical and mental health conditions, subject to any required authorization from Health Net or your Physician Group. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group.

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 Plan Contract and Evidence of Coverage.

Cardiac Rehabilitation Therapy

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

Clinical Trials

Routine patient care costs for items and services furnished in connection with participating in an approved clinical trial are covered when Medically Necessary, authorized by Health Net, and either the Member's treating Physician has recommended participation in the trial or the Member has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by non-participating providers are covered only when the protocol for the trial is not available through a participating provider within California. Services rendered as part of a clinical trial may be provided by a non-participating or participating provider subject to the reimbursement guidelines as specified in the law.

The following definition applies 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;
- 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.
- 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 standard provisions of Health Net, including drugs, items, devices and services that would normally be covered under this Plan Contract, if they were not provided in connection with a clinical trials program.

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

Pulmonary Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered Medically Necessary when continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

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 (formerly Expanded Alpha-Fetoprotein Program) administered by the California State Department of Public Health and are covered at no cost to the Members. Please refer to the "Schedule of Benefits and Copayments," Section 400 for Copayment requirements.

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

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

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

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

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

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

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 males and females is covered as described in the "Family Planning" portion of "Schedule of Benefits and Copayments." Sterilization of females and women's contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Prescribed contraceptives for women are covered as described in the

"Prescription Drugs" portion of this "Covered Services and Supplies" section of this Plan Contract and EOC.

Fertility Preservation

This Plan covers Medically Necessary services and supplies for standard fertility preservation treatments 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 “Schedule of Benefits and Copayments,” Section 400, as would be required for covered services to treat any illness or condition under this Plan.

Medical Social Services

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

Patient Education

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

Home Health Care Services

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

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

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

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive home infusion therapy. See “Definitions,” Section 1100. Custodial Care services and Private Duty Nursing, as described in "Definitions," Section 1100 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, including any portion of shift care services. Private Duty Nursing (or shift care) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See “Definitions,” Section 1100.

Outpatient Infusion Therapy

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

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

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

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

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

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

- Infusion medication administered in an outpatient Hospital setting that can be administered in the home or a non-Hospital infusion suite setting;
- Non-prescription drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met);

- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Ambulance Services

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

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

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible and they must authorize the services. Nonemergency ambulance and psychiatric transport van services are covered when Medically Necessary and when your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and when the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from covered services. Please refer to the "Ambulance Services" provision of "Exclusions and Limitations," Section 800 for additional information.

Hospice Care

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

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

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

Durable Medical Equipment

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

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

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

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

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

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

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

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

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

For adults age 19 and older, special Contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic Contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic Contact Lens if we provided an allowance toward (or otherwise covered) more than six aphakic Contact Lenses for that eye during the same Calendar Year. For children up to age 19, who are covered under pediatric vision services until the last day of the month in which they turn nineteen years of age, see “Pediatric Vision Services” portion of “Covered Services and Supplies” for coverage details.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of "Exclusions and Limitations," Section 800. Please refer to "Schedule of Benefits and Copayments," Section 400 for the applicable Copayment.

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

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

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including those listed below. The applicable Diabetic Equipment copayment will apply, as shown in “Schedule of Benefits and Copayments,” Section 400.

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

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

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

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

Bariatric (Weight Loss) Surgery

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

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

If you live 50 miles or more from the nearest Health Net Bariatric Surgery Performance Center, you are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by Health Net.

Approved travel-related expenses will be reimbursed as follows:

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

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

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

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

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

Evaluation of potential candidates is subject to prior authorization. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is determined to be 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.

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

Renal Dialysis

Renal dialysis services in your home service area are covered. Dialysis services for Members with end-stage-renal disease (ESRD) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of your home service area must be arranged and authorized by your Physician Group or Health Net in order to be performed by providers in your temporary location. Outpatient dialysis received out of the United States is not a covered service. See "Durable Medical Equipment" portion of this "Covered Services and Supplies" section.

Ostomy and Urological Supplies

Ostomy and urological supplies are covered under the "Prostheses" benefit as shown under "Medical Supplies" in "Schedule of Benefits and Copayments," Section 400, and include the following:

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

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 accord with Medicare guidelines.

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

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

Prostheses are covered as shown under “Medical Supplies” in “Schedule of Benefits and Copayments,” Section 400.

Blood

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

Inpatient Hospital Confinement

Covered services include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary;
- Physician services;
- Specialized and critical care;
- General nursing care;
- Special duty nursing as Medically Necessary);
- Operating, delivery and special treatment rooms;

- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services;
- Durable Medical Equipment and supplies;
- Medical social services;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

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
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 800.

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

Health Net and the Contracting Physician Group determine the feasibility and extent of these services, except that, the length of hospital stays related to mastectomies (including lumpectomies) and lymph node dissections will be determined solely by the Physician and no prior authorization for determining the length of stay is required.

This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

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

Women's Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also "Prostheses" in this "Covered Services and Supplies" section for a description of coverage for prostheses.

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 an 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-rays, radiation therapy and chemotherapy) are subject to the same Copayment which is required when these services are performed at your physician group.

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

Copayments for the other services will be the same as if they had been performed at your Physician Group.

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than Copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Facility Services" in "Schedule of Benefits and Copayments," Section 400 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 Hospital's most common charge for a two-bed room, unless a private room is Medically Necessary. Covered services at a Skilled Nursing Facility include the following services:

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

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

Benefits are limited to the number of days of care stated in "Schedule of Benefits and Copayments," Section 400.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

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

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

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.

Telehealth Services

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

Telehealth Consultations Through the Select Telehealth Services Provider

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

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

Prescription Drug Orders received from the Select Telehealth Services Provider Physician or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the “Prescription Drugs” portion of the “Schedule of Benefits and Copayments” section and the coverage and prior authorization requirements, exclusions and limitations shown in the “Prescription Drugs” portions of the “Covered Services and Supplies” and Exclusions and Limitations” sections.

These services are subject to the limitations described in the “Telehealth Consultations Through the Select Telehealth Services Provider” portion of “Exclusions and Limitations,” Section 800.

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

Subsection-B

Prescription Drugs

Please read the "Prescription Drugs" portion of "Exclusions and Limitations," Section 800.

You must satisfy the Prescription Drug Calendar Year Deductible shown in "Schedule of Benefits and Copayments," Section 400, before benefits for Prescription Drugs become payable by Health Net.

Covered Drugs and Supplies

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "Exclusions and Limitations," Section 800 of this Plan Contract to find out if a particular condition is not covered.

Tier 1 Drugs (Most Generic Drugs and Low Cost Preferred Brand Name Drugs) and Tier 2 Drugs (Non-preferred Generic Drugs, Preferred Brand Name Drugs, Certain Brand Name Drugs with a Generic Equivalent or Drugs Recommended by Health Net's Pharmaceutical and Therapeutics Committee Based on Drug Safety, Efficacy and Cost)

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

Tier 3 Drugs

Tier 3 Drugs are Prescription Drugs that are non-preferred Brand Name Drugs, drugs that generally have a Preferred and often less costly therapeutic alternative at a lower Tier, Drugs recommended by Health Net's Pharmaceutical and Therapeutics Committee based on drug safety, efficacy and cost, Brand Name Drugs with generic equivalents (when Medically Necessary), drugs listed as Tier 3 Drugs in the Essential Rx Drug List, drugs indicated as "NF," if approved, or drugs not listed in the Essential Rx Drug List.

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

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

Tier 4 (Specialty Drugs)

Tier 4 (Specialty Drugs) are specific Prescription Drugs that may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes biologics and drugs that the FDA or drug manufacturer requires to be distributed through a Specialty Pharmacy, or have high cost as established by Covered California. Tier 4 (Specialty Drugs) are identified in the Essential Rx Drug List with "SP". Refer to Health Net's Essential Rx Drug List on our website at healthnet.com for the Tier 4 (Specialty Drugs) listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

All Tier 4 (Specialty Drugs) require Prior Authorization from Health Net and may be required to be dispensed through the specialty pharmacy vendor to be covered. Tier 4 (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 Tier 4 (Specialty Drugs), which are subject to Prior Authorization and must be obtained through Health Net's contracted specialty pharmacy

vendor. Your Primary Care Physician or treating Physician will coordinate the authorization and upon approval the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor may contact you directly to coordinate the delivery of your medications.

Generic Equivalents to Brand Name Drugs

Generic Drugs will be dispensed when a Generic Drug equivalent is available, subject to the Copayment requirements described in the "Prescription Drugs" portion of "Schedule of Benefits and Copayments," Section 400.

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
   a. The drug is prescribed by a participating licensed health care professional for the treatment of a life -threatening condition; OR
   b. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Essential Rx Drug List or Prior Authorization by Health Net has been obtained for such drug; 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; AND
4. The drug is otherwise Medically Necessary.

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

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

   a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;
   b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered when at least one of the primary ingredients is on the Essential Rx Drug List and there is no similar commercially available product. Coverage for Compounded Drugs is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the “Off-Label Drugs” provision in the “Prescription Drugs” portion of “Covered Services and Supplies,” for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier 3 Drug Copayment and is subject to Prior Authorization by the Plan and Medical Necessity.

Diabetic Drugs and Supplies

Prescription drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential Rx Drug List. Diabetic supplies are also covered including but not limited to specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this Section for additional information. Refer to "Schedule of Benefits and Copayments," Section 400 under “Diabetic Equipment,” for details about the supply amounts that are covered and the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

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

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. These Prescription Drugs are covered for up to the number of doses or tablets specified in the Essential Rx Drug List. For information about the Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.

Preventive Drugs and Women’s Contraceptives

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

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

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

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

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

For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy. Emergency contraceptives required in conjunction with Emergency Care, as defined under "Definitions", Section 1100, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Care as defined.

The Essential Rx Drug List

What Is the Health Net Essential Rx Drug List?

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

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

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

The Essential Rx Drug List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the Essential Rx Drug List, the committee

reviews medical and scientific publications, relevant utilization experience, State and Federal requirements and Physician recommendations to assess the drug for its:

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

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

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

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

Prior Authorization Process for Prescription Drugs

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

Most Brand Name Drugs that have generic equivalents will require Prior Authorization to determine Medical Necessity. If approved for Medical Necessity, Health Net will cover Brand Name Drugs that have generic equivalents when Medically Necessary and the Physician obtains approval from Health Net.

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

Health Net must also notify the Member or his or her designee of its decision. If Health Net fails to respond within the required time limit, the Prior Authorization request is deemed granted.

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

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

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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

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

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

Participating Pharmacies located in Riverside and Sonoma Counties can dispense up to three times the 30-day-consecutive-calendar-day supply amount in one fill for maintenance medications, provided the Prescription Drug Order stipulates refills. One 30-day copayment, as shown in the "Schedule of Benefits and Copayments" section, will continue to apply for each 30-consecutive-day-supply dispensed.

If your 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 and Copayment shown in "Schedule of Benefits and Copayments," Section 400.

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

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

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID Card. After 30 days, Prescription Drugs dispensed by a Nonparticipating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in "Definitions," Section 1100 of this Plan Contract.

If the above situation applies to you:

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

Health Net will reimburse you for the cost of the Prescription Drug covered expenses, less any required Deductible and Copayment shown in "Schedule of Benefits and Copayments," Section 400.

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

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

Note:

- The Prescription Drug portion of "Exclusions and Limitations" in Section 800 and the requirements of the Essential Rx Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.
- *Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at* www.myhealthnetca.com,

Drugs Dispensed by Mail Order

If your prescription is for a Maintenance Drug, you have the option of filling it through our convenient mail order program. Maintenance Drug 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.

To receive Prescription Drugs by mail send the following to the designated mail order administrator:

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

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

The mail order administrator may only dispense up to a 90-consecutive calendar day supply of a covered Maintenance Drug and each refill allowed by that order. After you satisfy the Prescription Drug Calendar Year Deductible, if applicable, the required Copayment applies each time a drug is dispensed.

Note:

- Tier 4 (Specialty Drugs) and Schedule II narcotic drugs are not covered through mail order. Refer to the Prescription Drug portion of "Exclusions and Limitations" in Section 800 for more information.

Subsection-C

Mental Disorders and Chemical Dependency

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

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

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

The Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator) which contracts with Health Net to administer these benefits. 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 I.D. card.

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

- Outpatient procedures that are not part of an office visit (for example: psychological and neuropsychological testing, outpatient electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS)), outpatient detoxification, partial hospitalization, day treatment and half-day partial hospitalization;
- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing and intensive outpatient services; and
- Behavioral health treatment for Pervasive Developmental Disorder or Autism (see below under “Outpatient Services”).

The Administrator will help you identify a nearby Participating Mental Health Professional, participating independent physician or a subcontracted independent provider association (IPA) within the network and with whom you can schedule an appointment, as discussed in “Introduction to Health Net,” Section 300. The designated Participating Mental Health Professional, independent Physician or IPA will evaluate you, develop a treatment plan for you, and submit that treatment plan to the Administrator for review. Upon review and authorization (if authorization is required) by the Administrator or IPA, the proposed services will be covered by this Plan if they are determined to be Medically Necessary.

If services under the proposed treatment plan are determined by the Administrator to not be Medically Necessary, as defined in “Definitions,” Section 1100, services and supplies will not be covered for that condition. However, the Administrator may direct you to community resources where alternative forms of assistance are available. See “General Provisions,” Section 900(i) 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.myhealthnetca.com and select the MHC link or contact the Administrator at the Health Net Customer Contact Center phone number shown on your Health Net I.D. card.

In an emergency, call "**911**" or go to the nearest Hospital. If your situation is not so severe, or if you are unsure of whether an emergency condition exists, you may call the Administrator at the Customer Contact Center telephone number shown on your Health Net ID Card. Please refer to the "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 300, for more information.

Transition of Care For New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a non-Participating Mental Health Professional at the time you enroll with Health Net, and your prior coverage was an individual plan that was terminated due to the health plan or health insurer no longer offering your health plan, we may temporarily cover services from a provider not affiliated with the Behavioral Health Administrator, subject to applicable Copayments and any other exclusions and limitations of this Plan.

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

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

The following benefits are provided:

Outpatient Services

Outpatient services are covered as shown in "Schedule of Benefits and Copayments," Section 400, under “Mental Disorders and Chemical Dependency Benefits.

Covered Services include:

- Outpatient office visits/professional consultation including Chemical Dependency: Including outpatient crisis intervention, short-term evaluation and therapy, medication management, drug therapy monitoring, longer-term specialized therapy and individual and group mental health evaluation and treatment.

- Outpatient services other than an office visits/professional consultation, including Chemical Dependency: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Disorder, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization program. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism, as shown in the "Schedule of Benefits and Copayments," Section 400, under "Mental Disorders and Chemical Dependency Benefits."
    - The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, 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 the Administrator.
    - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
    - The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
    - Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Second Opinion

You may request a second opinion when:

- Your Participating Mental Health Professional renders a diagnosis or recommends a treatment plan that you are not satisfied with,
- You are not satisfied with the result of the treatment you have received,

- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition,
- Your Primary Care Physician or a referral Physician is unable to diagnose your condition or test results are conflicting;
- The treatment plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care; or
- If you have attempted to follow the plan of care you consulted with the initial Primary Care Physician or a referral Physician due to serious concerns about the diagnosis or plan of care.

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

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

Any service recommended by the second opinion must be authorized by the Administrator in order to be covered.

Inpatient Services

Inpatient treatment of Mental Disorders or Chemical Dependency is covered, as shown in "Schedule of Benefits and Copayments," Section 400 under "Mental Disorders and Chemical Dependency Benefits."

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary SED or SMI services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations," Section 800.

Detoxification and Treatment for Withdrawal Symptoms

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

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 400.

Serious Emotional Disturbances of a Child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one years; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness (SMI)

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 400.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with professionally recognized standards including but not limited to the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as amended to date)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Other Mental Disorders

Other Mental Disorders are all other Mental Disorders not listed under Severe Mental Illness, Serious Emotional Disturbances of a Child or Chemical Dependency conditions and are covered as shown in the "Schedule of Benefits and Copayments," Section 400 under “Mental Disorders and Chemical

Dependency Benefits.” In addition to the coverage required for Severe Mental Illness (“SMI”) and Serious Emotional Disturbances of a Child (“SED”) as described above, this plan covers Medically Necessary treatment for all Essential Health Benefits, including “mental disorders” described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as amended in the most recently issued edition. See also "Mental Disorders” in the ”Definitions” section.

Transitional residential recovery Services

Transitional residential recovery services for substance use disorder in a licensed recovery home when approved by the Administrator are covered.

Subsection-D

Pediatric Vision Services

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

The pediatric vision services benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc. to administer the pediatric vision services benefits.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

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

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

Examination

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

Contact Lens Fit and Follow-up Examination

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

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

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

Low Vision

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

Materials - Frames

If an examination indicates the necessity of eyeglasses, this vision benefit will cover one frame, up to the maximum number described in the “Pediatric Vision Services” portion of the “Schedule of Benefits and Copayments” section. See the “Pediatric Vision Services” portion of the “Schedule of Benefits and Copayments” section for limitations.

Materials - Eyeglass Lenses

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

Cosmetic Contact Lenses

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

Medically Necessary Contact Lenses

Coverage for prescriptions for Medically Necessary contact lenses is subject to Medical Necessity and all applicable exclusions and limitations. Contact Lenses are considered Medically Necessary when at least one of the following conditions applies:

- At least one natural lens is removed through cataract surgery and is not replaced with a lens implant (aphakia);
- Contact Lenses are necessary because of keratoconus, when visual acuity cannot be corrected to 20/40 with the use of spectacles;
- They are necessary because of anisometropia 3 diopters or more, provided visual acuity improves to 20/40 or better in the weaker eye;
- They are necessary because of astigmatism of 3 diopters or more;
- They are necessary because of hyperopia of greater than 7 diopters; or
- They are necessary because of myopia of greater than 12 diopters.

Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Aniseikonia, Corneal Disorders and Post-traumatic Disorders.

For coverage of Medically Necessary Contact Lenses to treat conditions of aniridia, see the “Durable Medical Supplies” under the “Medical Services and Supplies” portion of “Covered Services and Supplies.”

Contact Lenses for Conditions of Aphakia

Special Contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic Contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic Contact Lens if we provided an allowance toward (or otherwise covered) more than six aphakic Contact Lenses for that eye during the same Calendar Year. For adults age 19 and older, see the “Durable Medical Equipment” portion of “Covered Services and Supplies” for coverage details.

Subsection-E

Pediatric Dental Services

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

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

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

Choice of Provider

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

Facilities

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

Medically Necessary Dental Services

Medically Necessary dental services are dental benefits which are necessary and appropriate for treatment of a Member’s teeth, gums and supporting structures according to professionally recognized standards of practice and is:

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of the teeth and supporting tissues of the teeth

New Patient and Routine Services

As a member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that

an appointment be scheduled on a specific date, day of the week, or time of day, the Selected General Dentist may need additional time to meet your special request.

Making an Appointment

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

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

Specialist Referrals

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

Orthodontic Benefits

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

Referrals To Specialists For Orthodontic Care

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

Changing Your Selected General Dentist

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

Second Opinions

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

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

Fax: 714-364-6266

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

1. If you question the reasonableness or necessity of recommended surgical procedures.
2. If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
3. If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.
4. If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

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

Copayments

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

specifically authorized by us or in accordance with emergency care provisions. We do not require claim forms.

Dental Customer Service

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

Subsection-F

Acupuncture Services

Please read "Acupuncture Services" portion of "Exclusions and Limitations," Section 800.

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

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

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

All covered Acupuncture Services require verification of Medical Necessity by ASH Plans except:

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

The following benefits are provided for Acupuncture Services:

Office Visits

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

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

- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.

Second Opinion

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

EXCLUSIONS AND LIMITATIONS (SECTION 800)

It is extremely important to read this section before you obtain services in order to know what Health Net will and will not cover. Health Net does not cover the services or supplies listed below. Also services or supplies that are excluded from coverage in the Plan Contract, exceed Plan Contract limitations or are Follow-up Care (or related to Follow-up Care) to Plan Contract exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery). Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic health care service under applicable law (see "Regulation" at Section 900 D below), or is required to be covered by other state or federal law, and is Medically Necessary as defined in Section 1100 Definitions. Notwithstanding any exclusions or limitations described in this EOC, all Medically Necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.

General Exclusions and Limitations

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this Plan Contract.

Ambulance Services

Air and ground ambulance and ambulance transport services are covered as shown in the "Ambulance Services" provision of "Covered Services and Supplies," Section 700.

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;
- If Health Net determines that the criteria for Emergency Care as defined in "Emergency Care" under "Definitions," Section 1100, were not met, unless authorized by your Physician Group, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies," Section 700; 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.

Clinical Trials

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

- The Investigational drug, item, device or service itself;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;

- Health care services that are specifically excluded from coverage under this Plan Contract; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care

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

Custodial Care, as described in “Definitions,” Section 1100, is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient’s condition or provide for the patient’s comforts or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant, physical, speech or occupational therapist or other licensed health care provider.

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

CVS MinuteClinic Services

Services required for the treatment of Emergency Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit.

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

Disposable Supplies for Home Use

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

Experimental or Investigational Services

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

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

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

Home Birth

A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in this Plan Contract, have been met.

Ineligible Status

This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered.

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

No-Charge Items

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

Non-Enrolled Newborns

Any charges incurred by a baby beyond 30 days of its birth are excluded unless the baby is enrolled under this health plan within 30 days of its birth.

Nonparticipating Providers

Services and supplies rendered by a nonparticipating provider without authorization from Health Net or the Physician Group. However, Health Net or the Physician Group may authorize covered services from a nonparticipating Specialist or ancillary provider when the Member cannot obtain Medically Necessary care from such a participating 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 a nonparticipating provider of that type is within such reasonable distance. When Health Net or the Physician Group authorizes such care, the Member will pay the copayment levels described in the “Schedule of Benefits and Copayments” section of this Plan Contract and EOC.

Personal or Comfort Items

This Plan does not cover personal or comfort items.

Subsection-B

Services and Supplies

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

Aqua or Other Water Therapy

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

Aversion Therapy

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

Biofeedback

Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain disorders such as incontinence and chronic pain, and may otherwise require preauthorization by the Administrator.

Blood

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

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See “General Provisions,” Section 900, for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Chiropractic Care

This Plan does not cover chiropractic care.

Cosmetic Services and Supplies

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

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

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

Then the following are covered:

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;

- Surgery to remove or reduce skin or tissue are covered; or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

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

Dental Services

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

- When immediate emergency care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 300, for more information. For urgent or unexpected dental conditions that occur after-hours or on weekends, please refer to the “Pediatric Dental Services” portion of “Introduction to Health Net,” Section 300.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in the 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 and are subject to the other exclusions and limitations of this Plan Contract 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.

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

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.

- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or Orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD/TMJ disorders are covered if they are Medically Necessary, as described in the “Disorders of the Jaw” provision of this section.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 700) or as indicated on the U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations.

Disorders of the Jaw

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

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

  TMD/TMJ 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.

Durable Medical Equipment

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

- Exercise equipment.
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.

- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the “Prostheses” provision of “Covered Services and Supplies,” Section 700, and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of "Covered Services and Supplies," Section 700.

Fertility Preservation

Standard fertility preservation treatments are covered as shown in the “Fertility Preservation” provision in “Covered Services and Supplies,” Section 700. However, 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)

Genetic Testing and Diagnostic Procedures

Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing physician must request prior authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a member has no medical indication or family history of a genetic abnormality.

Hearing Aids

This Plan does not cover any device inserted in or affixed to the outer ear to improve hearing.

Home Birth

A birth which takes place at home will be covered only when the criteria for Emergency Care, as defined in this Plan Contract, have been met.

Immunizations and Injections

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

Infertility Services

This Plan does not cover services or supplies to diagnose, evaluate or treat infertility. Excluded procedures include, but are not limited to:

- Conception by medical procedures, such as artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.

Massage Therapy

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

Noncovered Treatments

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

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

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

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

This plan covers Medically Necessary treatment for all Essential Health Benefits, including “mental disorders” described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as amended in the most recently issued edition.

Noneligible Institutions

This Plan only covers Medically Necessary services or supplies provided by a licensed Hospital, Hospice, Medicare-approved Skilled Nursing Facility, Residential Treatment Center or other properly

licensed medical facility specified as covered in this Plan Contract. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.

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

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

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

Nonstandard Therapies

Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage see the “Independent Medical Review of Investigational or Experimental Therapies” portion of the “General Provisions.”

Physician Self-Treatment

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

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in the "Prescription Drug Benefits" portion of "Covered Services and Supplies, Section 700.

Private Duty Nursing

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

Psychological Testing

Psychological testing, except as conducted by Participating Mental Health Professionals who are licensed and acting within the scope of their license, for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.

Refractive Eye Surgery

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

Rehabilitation and Habilitation Therapy

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

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

Residential Treatment Center

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

Reversal of Surgical Sterilization

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

Routine Foot Care

Routine foot care including callus treatment, corn paring or excision, toenail trimming, massage of any type and treatment for fallen arches, flat or pronated feet are not covered unless Medically Necessary for a diabetic condition or peripheral vascular disease. Additionally, treatment for cramping of the feet, bunions and muscle trauma are excluded, unless Medically Necessary.

Annual Physical Examinations

This Plan does not cover annual physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes. An annual physical examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations

administered at the request of a third party, such as a school, camp or sports organization. See ”Preventive Care Services” in “Covered Services and Supplies,” Section 700, for information about coverage of examinations that are for preventive health purposes.

Services for Educational or Training Purposes

Except for services related to behavioral health treatment which are covered as shown in “Covered Services and Supplies,” Section 700, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California. Examples of excluded services include education and training for non-medical purposes such as:

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

Services Not Related to Covered Condition, Illness or Injury

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

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an Emergency or Urgently Needed Care as defined in "Definitions," Section 1100.

Sports Activities

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

Surrogate Pregnancy

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

payable under this provision are subject to the Plan's right to recovery as described in "Surrogacy Arrangements" in the "General Provisions" section of this Plan Contract and EOC.

Telehealth Consultations Through the Select Telehealth Services Provider

Telehealth consultation through the Select Telehealth Services Provider do not cover:

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

Treatment by Immediate Family Members

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

Treatment for Obesity

Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity. Certain services may be covered as Preventive Care Services; refer to the "Preventive Care Services" provision in "Covered Services and Supplies," Section 700.

Treatment Related to Judicial or Administrative Proceedings

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

Unauthorized Services and Supplies

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

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

Vision Therapy, Eyeglasses and Contact Lenses

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

Prescription Drugs

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

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this Plan Contract. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

Additional exclusions and limitations:

Allergy Serum

Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See the “Allergy, Immunizations and Injections” portion of the “Schedule of Benefits and Copayments” section and the “Immunizations and Injections” portion of “Covered Services and Supplies” section.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs prescribed for the treatment of obesity are not covered, except when medically necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. The prescribing Physician must request and obtain Prior Authorization for coverage.

Brand Name Drugs that have Generic Equivalents

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

Devices

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

Diagnostic Drugs

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

Dietary or Nutritional Supplements

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

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

Drugs Prescribed for the Common Cold

Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed for Cosmetic or Enhancement Purposes

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

Food and Drug Administration (FDA)

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

Hypodermic Syringes and Needles

Hypodermic syringes and needles are limited to disposable insulin needles and syringes, and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net's specialty pharmacy vendor under the Medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies," Section 700). All other syringes, devices and needles are not covered.

Infertility Services

This Plan does not cover prescription drugs prescribed for infertility.

Self-Injectable Drugs

Self-injectable drugs obtained through a prescription from a Physician are limited to insulin, sexual dysfunction drugs and injections listed on the Essential Rx Drug List. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies (Section 700)." Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of "Covered Services and Supplies."

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs

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

Nonapproved Uses

Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the "Off-Label Drugs" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 700).

Noncovered Services

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

Nonparticipating Pharmacies

Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the " Nonparticipating Pharmacies and Emergencies" provision of "Covered Services and Supplies," Section 700.

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

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

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

Physician Is Not a Member Physician

Drugs prescribed by a Physician who is not a Member Physician or an authorized Specialist are not covered, except when the Physician’s services have been authorized or because of a medical Emergency condition, illness or injury or as specifically stated.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment based on recommendations for use by the FDA or Health Net’s usage guidelines. Medications taken on an “as-needed” basis may have a Copayment based on a specific quantity, standard package, vial, ampoule, tube or other standard unit.

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

Schedule II Narcotic Drugs

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

Sexual Dysfunction Drugs

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period.

Unit Dose or "Bubble" Packaging

Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Subsection-D

Pediatric Vision Services

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Pediatric Vision Services.

Note: Services or supplies excluded under the vision benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

Additional exclusions and limitations:

Non-Participating Providers

This vision plan will not cover services and supplies provided by a provider who is not a Participating Vision Provider.

Not-Medically Necessary Services and Materials

Charges for services and Materials that Health Net determines to be non-Medically Necessary services, are excluded. One routine eye examination with dilation is covered every calendar year, and is not subject to Medical Necessity.

Medically Necessary Contact Lenses

Coverage for prescriptions for contact lenses is subject to Medical Necessity all applicable exclusions and limitations. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames. See the “Pediatric Vision Services” portions of “Schedule of Benefits and Copayments” and “Covered Services and Supplies” for details.

Medical or Hospital

Hospital and medical charges of any kind, vision services rendered in a hospital and medical or surgical treatment of the eyes, are not covered.

Loss or Theft

Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular time intervals of coverage under this plan.

Orthoptics, Vision Training, etc.

Orthoptics and vision training and any associated testing, subnormal vision aids, plano (non-prescription) lenses, lenses are excluded unless specifically identified as a Covered Service in the “Pediatric Vision Services” portion of “Schedule of Benefits and Copayments” section.

Second Pair

A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

Employment Related

Any services or Materials as a condition of employment (e.g., safety glasses). Noted Exception: If the service is determined to be Medically Necessary, irrespective of whether a condition of employment also requires it, the service is covered.

Medical Records

Charges associated with copying or transferring vision records are excluded. Noted Exception: If Health Net’s contracting provider terminates, lacks capacity or the enrollee is transferred for other good cause, the enrollee is not required to pay the charges associated with copying or transferring vision records to the participating provider in order to obtain covered services.

Subsection-E

Pediatric Dental Services

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Pediatric Dental Services. See the “Pediatric Dental Services” portion of the “Schedule of Benefits and Copayments” section for additional limitations.

Note: Services or supplies excluded under the dental benefits may be covered under your medical benefits portion of this Plan Contract and Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

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

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

Additional exclusions and limitations:

Implant Services (D6000-D6199)

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.

Medically Necessary Orthodontia (D8000-D8999)

Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

a. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

b. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

c. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

d. The automatic qualifying conditions are:
    i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

    ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

    iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

iv. A crossbite of individual anterior teeth causing destruction of soft tissue,

v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

vi. A severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

If a member does not score 26 or above nor meets one of the six automatic qualifying conditions, he/she may be eligible under the Early and Periodic Screening, Diagnosis and Treatment - Supplemental Services (EPSDT-SS) exception if medically necessity is documented.

Adjunctive Services (D9000-D9999)

Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;

a. Palliative treatment (relief of pain)

b. Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.

c. House/extended care facility calls, once per member per date of service.

d. One hospital or ambulatory surgical center call per day per provider per member.

e. Anesthesia for members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require Prior Authorization.

f. Occlusal guards when medically necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition.

Services which, in the opinion of the attending dentist or Health Net, are not Medically Necessary

The following services, if in the opinion of the attending dentist or Health Net are not Medically Necessary, will not be covered:

- Any procedure that in the professional opinion of the attending dentist: a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or b) is inconsistent with generally accepted standards for dentistry.
- Temporomandibular joint treatment (aka "TMJ").
- Elective Dentistry and cosmetic dentistry.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.
- Prescription Medications.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.

- Any procedure of implantation.
- Any Experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process. Please refer to the “Independent Medical Review of Investigational or Experimental Therapies” portion of the “General Provisions” section set forth in the Plan Contract for your health plan with Health Net for more information.
- General anesthesia or Intravenous/Conscious sedation, except as specified in the medical benefits portion of this Plan Contract and EOC. See “Exclusions and Limitations (Section 800),” “Dental Services.”
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the Member’s responsibility. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a Covered Service.
- Services that were provided without cost to the Member by State government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the Member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.
- Pediatric dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

Missed Appointments

Keep scheduled appointments or contact the dental office twenty-four (24) hours in advance to cancel an appointment. If you do not, you may be charged a missed appointment fee.

Subsection-F

Acupuncture Services

The exclusions and limitations in the “General Exclusions and Limitations” and "Services and Supplies" portions of this section also apply to Acupuncture Services.

Note: Services or supplies excluded under the acupuncture benefits may be covered under your medical benefits portion of this *Plan Contract*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

Services, laboratory tests, x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research

stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

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

Auxiliary Aids

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

Diagnostic Radiology

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

Drugs

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

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

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

Experimental or Investigational Acupuncture Services

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

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Anesthesia

Charges for anesthesia are not covered.

Hypnotherapy

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

Non-Contracted Providers

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

Thermography

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

Transportation Costs

Transportation costs are not covered, including local ambulance charges.

X-ray and Laboratory Tests

X-ray and laboratory tests are not covered.

Medically/Clinically Unnecessary Services

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

Services Not Within License

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

Vitamins

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

GENERAL PROVISIONS (SECTION 900)

Subsection-A

Form or Content of the Plan Contract

Only a Health Net officer can make changes to this Plan Contract. Any changes will be made through an endorsement signed and authorized by a Health Net officer. No agent or other employee of Health Net is authorized to change the terms, conditions or benefits of this Plan Contract.

Subsection-B

Entire Agreement

This Plan Contract, the Notice of Acceptance and the application shall constitute the entire agreement between Health Net and the Member.

Subsection-C

Right to Receive and Release Information

As a condition of enrollment in this health plan and a condition precedent to the provisions of benefits under this health plan, Health Net, its agents, independent contractors and participating physicians shall be entitled to release to or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which Health Net requires or is obligated to provide pursuant to legal process, federal, state or local law or as otherwise required in the administration of this health plan.

Subsection-D

Regulation

Health Net is subject to the requirements and the implementing regulations of the California Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code (beginning with Section 1340) and its implementing regulations, as set forth at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations (beginning with Section 1300.43). Any provisions required to be in this Plan Contract by either of the above sources of law shall bind Health Net whether or not provided in this Plan Contract.

Subsection-E

Notice of Certain Events

Any notices required hereunder shall be deemed to be sufficient if mailed to the Subscriber at the address appearing on the records of Health Net. The Subscriber can meet any notice requirements by

mailing the notice to: Health Net Individual Products, P.O. Box 2066, Rancho Cordova, CA 95741-2066.

Subsection-F

Benefit or Subscription Charge Changes

Health Net will provide Subscriber at least 60 days' notice of any changes in benefits, Subscription Charges or Plan Contract provisions. There is no vested right to receive the benefits of this health plan.

Subsection-G

Non-Discrimination

Health Net hereby agrees that no person who is otherwise eligible and accepted for enrollment under this Plan Contract shall be refused enrollment nor shall their coverage be terminated solely because of race, color, national origin, ancestry, religion, sex, gender identity, gender expression, marital status, sexual orientation, age, health status or physical or mental handicap.

Subsection-H

Interpretation of Plan Contract

The laws of the State of California shall be applied to interpretations of this Plan Contract. Where applicable, the interpretation of this Plan Contract shall be guided by the direct service, group practice nature of Health Net's operations as opposed to a fee for service indemnity basis.

Subsection-I

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.

Members have the right to:

- Receive information about Health Net, its services, its practitioners and providers and Members' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to you;

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

Members have the responsibility and obligation to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon with their practitioners;
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Refrain from submitting false, fraudulent, or misleading claims or information to Health Net or your providers.

Subsection-J

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 Plan Contract and EOC, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of an individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Provider, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-888-926-4988** or by submitting a Member Grievance Form through the Health Net website at www.myhealthnetca.com.

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

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

If your concern involves the Mental Disorders and Chemical Dependency program, call MHN Services at **1-888-426-0030** or write to:

MHN Services
Attention: Appeals and Grievances
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the pediatric vision services, call Health Net **1-866-392-6058** or write to:

Health Net
Attention: Customer Contact Center
P.O Box 8504
Mason, OH 45040-7111

If your concern involves pediatric dental services, call Health Net at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130-0569

If your concern involves the acupuncture program, call the Health Net Customer Contact Center at **1-888-926-4988** or write to:

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

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

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

Eligibility

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

1. (A) Your provider has recommended a health care service as Medically Necessary, or

   (B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary;

   (C) In the absence of the provider recommendation described in 1.(A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

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

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

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

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review ("IMR") of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance 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 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 you are entitled to. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on your Health Net ID card.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan.)

If you have a grievance against Health Net, you should first telephone Health Net at **1-888-926-4988** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net or a grievance that has remained unresolved for more than 30 days, 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 http://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 THOS DESCRIBED BELOW AND YOU AGREE NOT TO PURSUE ANY CLAIMS ON A CLASS ACTION BASIS. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between the parties and thereby the parties agree to forego any right they may have to a jury trial on such disputes.** However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health

Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

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

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

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

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

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

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

Subsection-K

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

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

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician, or the Physician Group. Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the Physician Group or at another Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.
- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.
- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.
- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if it is determined that your residence is not within reasonable access to your current Primary Care Physician.

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

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

Subsection-L

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or

devices. New technologies are considered Investigational or Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational or Experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or Investigational or Experimental, following extensive review of medical research by appropriately specialized Physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or Investigational or Experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Subsection-M

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.

Subsection-N

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

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

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

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

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

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

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

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

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

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

STEPS YOU MUST TAKE

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

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;

- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery, the full cost of all benefits paid by the plan; and
- Hold any money that you or your lawyer receive from the responsible parties, or from any other source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

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

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

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro 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 Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

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

Subsection-O

Surrogacy Arrangements

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

Your Responsibility for Payment to Health Net

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

Assignment of Your Surrogacy Payments

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

Duty to Cooperate

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

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

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

You must do nothing to prejudice the health plan's recovery rights. You must also provide us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

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

Subsection-P

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital or other health care provider.

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

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the effective date of the contract termination.

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

- An Acute Condition
- A Serious Chronic Condition not to exceed twelve months from the contract termination date
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the 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)

- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

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

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

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

Contracting Administrators

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

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

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.

Subsection-Q

Government Coverage

Medicare

If Medicare has made primary payment or is obligated to do so according to federal law and Health Net has provided services, Health Net will obtain reimbursement from Medicare, any organization or person receiving payments to which Health Net is entitled.

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.

MISCELLANEOUS PROVISIONS (SECTION 1000)

Subsection-A

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of Physician Groups. Your Physician Group performs or authorizes all care and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

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

Subsection-B

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.

Subsection-C

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit and that you have filed as soon as was reasonably possible.

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

If you need to file a claim for emergency services or for services authorized by your physician group or PCP with Health Net, please send a completed claim form to:

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

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.myhealthnetca.com to obtain a prescription drug claim form.

If you need to file a claim for Emergency Mental Disorders and Chemical Dependency or for other covered Mental Disorders and Chemical Dependency Services provided upon referral by the Administrator, MHN Services, you must file the claim with MHN Claims within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that it was not reasonably possible to file the claim within one year, and that it was filed as soon as reasonably possible. You must use the CMS (HCFA) - 1500 form in filing the claim and you should send the claim to MHN at the address listed in the claim form or to MHN Claims at:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

MHN Claims will give you claim forms on request. For more information regarding claims for covered Mental Disorders and Chemical Dependency Services, you may call MHN Claims at **1-800-444-4281** or you may write MHN Claims at the address given immediately above.

If you receive emergency pediatric dental services, you will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. For more information regarding claims for covered pediatric dental services, you may call Health Net at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130

To be reimbursed for emergency pediatric dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement.

Subsection-D

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.

Subsection-E

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 Physician Group personnel or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an Emergency, go to the nearest doctor or Hospital. See the “Emergency and Urgently Needed Care” section under “Introduction to Health Net,” Section 300.

Subsection-F

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.

Subsection-G

Confidentiality of Medical Records

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

Notice of Privacy Practices

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

Covered Entities Duties:

Health Net* (referred to as "we" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI 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
- Other privacy practices stated in the notice.

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

Internal Protections of Oral, Written and Electronic PHI:

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

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.

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

- 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
  - Performing utilization review of claims
- ***Health Care Operations*** - We may use and disclose Your PHI to perform Our health care operations. These activities may include:
  - Providing customer services
  - Responding to complaints and appeals
  - Providing case management and care coordination
  - Conducting medical review of claims and other quality assessment
  - Improvement activities

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

Other Permitted or Required Disclosures of Your PHI:

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

- Grand jury subpoena

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

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

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

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

Individuals Rights

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

- ***Right to Revoke an Authorization*** - You may revoke Your authorization at any 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. This right only applies if the information could endanger You if it is not communicated by the alternative means or to the alternative location You want. You do not have to explain the reason is for Your request, but You must state that the information could endanger You if the communication means or location is not changed. We must accommodate Your request if it is reasonable and specifies the alternative means or location where You PHI should be delivered.
- ***Right to Access and Receive Copy of Your PHI*** - You have the right, with limited exceptions, to look at or get copies of Your PHI contained in a designated record set. You may request that We provide copies in a format other than photocopies. We will use the format You request unless We cannot practicably do so. You must make a request in writing to obtain access to Your PHI. If We deny Your request, We will provide You a written explanation and will tell You if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

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

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

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

Contact Information

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

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

Telephone: **1-888-926-4988**
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

FINANCIAL INFORMATION PRIVACY NOTICE

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

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

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

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

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

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

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

Questions about this Notice:

If You have any questions about this notice:

Please **call the toll-free phone number on the back of Your ID card** or contact Health Net at **1-888-926-4988**.

DEFINITIONS (SECTION 1100)

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

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by ASH Plan to be Medically Necessary for the treatment of that condition. Acupuncture Services are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

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 services shall be provided for the duration of the acute condition.

Administrator is an affiliate behavioral health services administrator which contracts with Health Net to administer delivery of Mental Disorder and Chemical Dependency services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities. Health Net has contracted with MHN Services to be the Administrator.

American Specialty Health Plans of California, **Inc**. **(ASH Plans)** is a specialized health care service plan contracting with Health Net to arrange the delivery of Acupuncture Services through a network of Contracted Acupuncturists.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

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

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

Chemical Dependency is alcoholism, drug addiction or other chemical dependency problems.

Chemical Dependency Care Facility is a Hospital, residential treatment center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is state-licensed to provide Chemical Dependency detoxification services or rehabilitation services.

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

Copayment is a fee charged to you for covered services when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 400.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to,

disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Expenses/Services are Medically necessary medical, surgical, hospital and other services and supplies rendered by participating providers and emergency care and supplies provided by non-participating providers, which are specified as being covered in the Plan Contract.

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 which patient:

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

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

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

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

Deductible is a set amount you pay each calendar year for specified covered expenses before Health Net pays any benefits for those covered expenses in that calendar year. Refer to the "Schedule of Benefits and Copayments," Section 400, for the services that are subject to Deductibles and the Deductible amounts.

Dependent includes:

- The Subscriber's lawful spouse, as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined below.)
- The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).

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

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, it is not for convenience and/or comfort 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 Care includes medical screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as Medically Necessary.

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

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

Emergency Dental Care includes Medically Necessary services required for: (1) the alleviation of severe pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions. However, payment for Emergency Dental Care rendered will be conditioned on Health Net's subsequent review and determination as to consistency with professionally recognized standards of dental practice and Health Net's dental policies.

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

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

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

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory

patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Essential Rx Drug List 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.myhealthnetca.com. Some Drugs in the Essential Rx Drug List require Prior Authorization from Health Net in order to be covered.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions," Section 900, as well as the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for additional information.

With regard to Acupuncture Services, “Experimental” services are acupuncture care that is an unproven acupuncture service that does not meet professionally recognized, valid, evidence-based standards of practice.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member’s condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Health Care Services (including behavioral health care services) are those services that can only be provided by an individual licensed as a health care provider by the state of California to perform the services, acting within the scope of his/her license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members and provide benefits through approved Individual health plans. A listing of the participating Primary Care Physicians in the Health Net Service Area are available on the Health Net website at www.myhealthnetca.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.

Health Net Essential Rx 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.myhealthnetca.com. Some Drugs in the Essential Rx Drug List require Prior Authorization from Health Net in order to be covered.

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

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

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

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

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

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net will decide whether a service or supply is Investigational.

With regard to Acupuncture Services, "Investigational" services are acupuncture care that is investigatory.

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.

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

Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Subscriber or an enrolled family member.

Member Physician is a Physician who practices medicine as an associate of a Physician Group.

Mental Disorders are syndromes characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflect a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. This plan covers Medically Necessary treatment for all Essential Health Benefits, including "mental disorders" described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, as amended in the most recently issued edition.

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.

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

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

Out-of-Pocket Maximum is the maximum amount of Copayments and you must pay for Covered Services for each calendar year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid.

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 Disorder and Chemical Dependency benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Chemical Dependency rehabilitation services.

Participating Dentist is a dentist or dental facility licensed to provide Benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Dentists are set forth in Health Net's Participating Dentist Directory. The names of Participating Dentists and their locations and hours of practice may also be obtained by contacting Health Net's Customer Service Department. This plan does not guarantee the initial or continued availability of any particular Participating Dentist.

Participating Mental Health Professional is a Physician or other professional who is licensed, certified or otherwise authorized by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Disorder and Chemical Dependency services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Participating Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish such care to Members.

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

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

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

Physician Group is the Health Net contracting medical group the individual Member selected as the source of all covered medical care. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by you and described in this Plan Contract.

Plan Contract is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the “Preventive Care Services” heading as shown in “Schedule of Benefits and Copayments,” Section 400, and "Covered Services and Supplies," Section 700. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health
- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

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 Process for Prescription Drugs” in the “Prescription Drugs” portion of “Covered Services and Supplies” for details regarding the prior authorization process relating to prescription drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a hospital or skilled nursing facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care and includes any portion of shift care services."

Professional Vision Services include examination, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board with a certification, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional: (1) provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider; (2) is supervised by a Qualified Autism Service Provider; (3) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; (5) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; and (6) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and(5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a telehealth service provider that is contracted with Health Net to provide Telehealth Services that are covered under the “Telehealth Consultations through the Select Telehealth Services Provider” heading as shown in the “Schedule of Benefits and Copayments”

and "Covered 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.

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

Serious Emotional Disturbances of a Child exist when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one years; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as amended to date), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Subscriber is the person enrolled under this Plan Contract who is responsible for payment of premiums to Health Net and whose status is the basis for family member eligibility under this Plan Contract.

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 services shall be provided for the duration of a terminal illness.

Tier 1 Drugs are Prescription Drugs listed in the Health Net Essential Rx Drug List and include most Generic Drugs and low cost preferred Brand Name Drugs.

Tier 2 Drugs are Prescription Drugs listed in the Health Net Essential Rx Drug List and include non-preferred Generic Drugs, preferred Brand Name Drugs, and any other drugs recommended by Health Net's Pharmaceutical and Therapeutics Committee based on drug safety, efficacy and cost.

Tier 3 Drugs are Prescription Drugs listed in the Health Net Essential Rx Drug List and include non-preferred Brand Name Drugs, drugs that generally have a Preferred and often less costly therapeutic alternative at a lower Tier, and drugs recommended by Health Net's Pharmaceutical and Therapeutics Committee based on drug safety, efficacy and cost.

Tier 4 (Specialty Drugs) are Prescription Drugs listed in the Health Net Essential Rx Drug List and include drugs: (a) that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; (b) that require the Member to have special training or clinical monitoring for self-administration; or (c) with a cost to Health Net that is greater than $600.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

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

LANGUAGE ASSISTANCE SERVICES (SECTION 1200)

Health Net provides free language assistance services, such as oral interpretation, sign language interpretation, translated written materials and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual staff and interpreter services for additional languages to handle Member language needs. Oral 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.

NOTICE OF LANGUAGE SERVICES (SECTION 1300)

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 shich[' yidooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíį[' hodíilnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihį[' bikáá' éí doodago koj[' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí koj[' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí koj[' hólne' -888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí koj[' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (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) ਐਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੋਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੇਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

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

Spanish

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

Tagalog

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

Thai

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

Vietnamese

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

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

FLY017549EH00 (12/17)

NOTICE OF NONDISCRIMINATION (SECTION 1400)

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. ("Health Net") complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).**
- **Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.**

If you need these services, contact Health Net's Customer Contact Center at:

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 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc. Appeals & Grievances
P.O. Box 10348
Van Nuys, California, 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com **(Members) or**

Non-Member.Discrimination.Complaints@healthnet.com **(Applicants)**

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint**.**

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and

Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800–368–1019 (TDD: 1-800–537–7697).**

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html**.**

For more information, please contact us at:

Health Net Individual & Family Sales Enrollment Unit
Post Office Box 1150
Rancho Cordova, CA 95741-1150

Customer Contact Center
1.888.926.4988

www.myhealthnetca.com