PLAN CONTRACT AND EVIDENCE OF COVERAGE

A complete explanation of your Plan

Health Net of California IEX Ambetter PPO
Plan Contract and Evidence of Coverage
Bronze 60 HDHP Ambetter PPO AI-AN

PLAN: MAP
EOCID: 580181

Important benefit information - please read

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), a California health care services plan. 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: MAP

Health Net

Amy W. Krause
Secretary

J. Brian Ternan
President

About This Booklet

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

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

Method of Provider Reimbursement

Health Net pays Participating Providers on a fee-for-service basis, according to an agreed Contracted Rate. You may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on your Health Net ID card.

Use of Special Words

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

In addition, the following words are used frequently:

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

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TERM OF YOUR COVERAGE

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 the "Termination for Cause" portion of the "Eligibility, Enrollment and Termination" section. 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.

SUBSCRIPTION CHARGES

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 “Special Enrollment for Periods for 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*.

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 (f) 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 nonpayment 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 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" for information about the three-month grace period and the consequences for nonpayment 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 nonpayment 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, 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, credit card, or general purpose pre-paid debit card.

NOTE: This address is for initial application submission:

Health Net Ambetter Individual and Family Enrollment Unit
P.O. Box 989731
West Sacramento, CA 95798-9731

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 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

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) 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 nonpayment 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

The coverage described in this *Plan Contract* shall be consistent with the Essential Health Benefits (EHB) 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 and EOC* do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, and are not subject to any pre-existing condition or exclusion period.

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

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

EXCEPT FOR URGENT CARE AND EMERGENCY CARE, SERVICES AND SUPPLIES PROVIDED BY PROVIDERS OUTSIDE OF CALIFORNIA ARE NOT COVERED.

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

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

number on the back of your Member ID card to ensure that you can obtain the Health Care Services that you need.

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

How to Obtain Care - In-Network

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

To obtain a copy of the *Health Net Ambetter PPO Network Directory*, please contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.myhealthnetca.com. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more.

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

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

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

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

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

Choosing a Primary Care Physician

Health Net believes maintaining an ongoing relationship with a Physician who knows you well and whom you trust is an important part of a good health care program. That's why, as a Health Net PPO Member, you are required to select a Primary Care Physician for yourself and each member of your family, even though you may go directly to any Participating Provider without first seeing your Primary Care Physician.

You may designate any Primary Care Physician who participates in our network, who is available to accept you or your Family Members and who is close enough to your residence to allow reasonable access to medical care. Family Members may select different Primary Care Physicians. Some Physicians may decline to accept assignment of a Member whose home address is not close enough to the Physician to allow reasonable access to care. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician and a listing of the Participating Physicians in the Health Net Ambetter PPO 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 ID card to request provider information or if you have questions involving reasonable access to care. Primary Care Physicians includes general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

Selecting a Participating Mental Health Professional

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

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

Prescription Drugs

You must purchase covered drugs at a Participating Pharmacy in the Health Net Ambetter Pharmacy Network, except as described under "Nonparticipating Pharmacies and Emergencies" portion of "Covered Services and Supplies." Not all pharmacies that contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency or Urgently Needed Care, only those pharmacies specifically identified as participating in the Ambetter Pharmacy Network may provide the Prescription Drugs benefit under this Plan. For a list of pharmacies participating in the Ambetter Pharmacy Network, call our Health Net Customer Contact Center or visit our website at www.myhealthnetca.com. Pharmacies that are not in the Ambetter Pharmacy Network are considered Out-of-Network Pharmacies under this Plan. See the "Prescription Drugs" portion of "Covered Services and Supplies."

Specialists and Referral Care

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

Covered Services that are not Available Through a Preferred Provider

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

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

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

How to Obtain Care - Out-of-Network

Under the out-of-network benefit level, you may receive medical care in California from any licensed Out-of-Network Provider. Except for Urgent Care and Emergency Care, services and supplies provided by providers outside of California are not covered.

Out-of-Network Providers have not agreed to participate in the Health Net Ambetter PPO Network. Therefore, you lose the protection of Contracted Rates and must also submit claims for benefits. You will not be reimbursed for any amounts in excess of the Maximum Allowable Amount. Please refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and EOC* for more details on how we determine MAA.

Some of the Covered Expenses are subject to a requirement of Prior Authorization, or treatment review, in order for full benefits to be available to you. Please refer to the "Prior Authorization Requirement" section in this *Plan Contract and EOC* for additional information.

Specialists and Referral Care

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

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

Your Financial Responsibility

Preferred Providers

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

Out-of-Network Providers

Covered services or supplies from Out-of-Network Providers are paid at the out-of-network benefit level. Your share of cost is based on the Maximum Allowable Amount. For more information on how we determine the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and EOC*. You are responsible for any applicable Deductible, Copayments or Coinsurance payment, and any amounts billed in excess of the Maximum Allowable Amount. THEREFORE, WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.

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

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

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

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

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

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

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

Deductible

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

Nonauthorization Penalties

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

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

Questions

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

Timely Access to Care - Preferred Providers

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

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with a Participating Physician

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

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

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Urgent care appointment with non-Physician behavioral health care provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization:** within 96 hours of request.

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

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

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

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

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

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

Scheduling Appointments for In-Network Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

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

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

Transition of Care for New Enrollees

You may request continued care from a provider, including a Hospital that does not contract with Health Net if 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 your Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal Mental Health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

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

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments and any exclusions and limitations of this Plan at the in-network benefit level. 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 the Effective Date and you make the request as soon as reasonably possible. The Out-of-Network Provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider at the in-network benefit level.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or request a copy of the Continuity of Care

Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Emergency and Urgently Needed Care through Your PPO Plan

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

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

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

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

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

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

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

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

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

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

Prescription Drugs

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

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

Note:

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

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.

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 participating dental providers provide emergency dental services twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your participating dental provider. **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.

Bronze 60 HDHP Ambetter PPO AI-AN

SCHEDULE OF BENEFITS

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

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

Out-of-Network: Except for Emergency Care, when you receive care or services from an Out-of-Network Provider, you will be responsible for the applicable Deductible(s), Copayments, or a percentage of the Maximum Allowable Amount (Coinsurance) as stated after each benefit listed below under the heading "Out-of-Network Provider." (There are additional exceptions as stated in the "Introduction to Health Net" section.) *You will also be responsible for any charges the Out-of-Network Provider bills in excess of the Maximum Allowable Amount.* For more details about the Maximum Allowable Amount, refer to the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and Evidence of Coverage*. **Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.**

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

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

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

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 all items or services that are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under purchased/referred care. Referrals under purchased/referred care must be issued by an IHS provider, and must be authorized by IHS's Managed Care Committee. Cost sharing means Copayments, including Coinsurance, and Deductibles. Purchased/referred care means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the service, e.g., dentists, physicians, hospitals, and ambulances.

Services obtained at an Indian Health Care Provider do not apply toward any annual limits on visits services.

Calendar Year Deductible

Subscriber-only Coverage

	Preferred Provider	Out-of-Network Provider
Individual Calendar Year Deductible	$6,650	$13,300

Family Coverage

The following Calendar Year Deductibles apply to the Subscriber and Family Members who are covered under this *Plan Contract and Evidence of Coverage* as a family unit. They do not apply to subscriber-only coverage. The Member must meet the Individual Calendar Year Deductible before benefits are payable. All amounts applied toward the Individual Calendar Year Deductibles for each Member in a family unit will accumulate to meet the family Calendar Year Deductible. Once the family Calendar Year Deductible is met, no further Individual Calendar Year Deductibles for Members in the family unit will have to be satisfied during that Calendar Year.

	Preferred Provider	Out-of-Network Provider
Individual Calendar Year Deductible	$6,650	$13,300
Family Calendar Year Deductible	$13,300	$26,600

Note(s):

The Calendar Year Deductible is required for certain medical services and outpatient Prescription Drugs, unless indicated as "Deductible waived," and is applied to the Out-of-Pocket Maximum. You must pay an amount of Covered Expenses for these services equal to the Calendar Year Deductible shown above before the benefits are paid by your Plan. After the Deductible is satisfied, you remain financially responsible for paying any other applicable Copayments or Coinsurance until you satisfy the individual or family Out-of-Pocket Maximum. If you are a Member in a family of two or more Members, you reach the Deductible either when you meet the amount for any one Member, or when your entire family reaches the family amount. The Calendar Year Deductible does not apply to Preventive Care Services.

- If the Subscriber has Subscriber-only coverage and changes to family coverage (that is, adds Family Members, such as a newborn child), any amounts applied to the individual Calendar Year Deductible for Subscriber-only coverage will be applied to the individual and family Calendar Year Deductible for family coverage.
- If the Subscriber has family coverage and changes to Subscriber-only coverage (that is, removes all Family Members), any amounts applied to the individual Calendar Year Deductible for family coverage will be applied to the individual Calendar Year Deductible for Subscriber-only coverage.

- Any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from a Preferred Provider will not apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from an Out-of-Network Provider will not apply toward the Calendar Year Deductible for Preferred Providers.

Nonauthorization Penalties

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

	Preferred Provider	Out-of-Network Provider
Medically Necessary services for which Prior Authorization was required but not obtained	$250	$500

Note(s):

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

The nonauthorization penalty will not exceed the cost of the benefit to Health Net.

Prior Authorization is not required for services received from an IHCP, an Indian Tribe, Tribal Organization, or Urban Indian organization or through referral under purchased/referred care.

For a list of services which require Prior Authorization, please see the "Prior Authorization Requirement" section. The Coinsurance percentage applicable to the coverage of nonauthorized services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

Copayments and Coinsurance (Including any Additional Benefit Deductibles)

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

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

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Emergency room facility	0%	0%
Emergency room professional services	0%	0%
Urgent care center (facility and professional services)	0%	50%

Copayment Exceptions:

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

Note(s):

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

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider*
Emergency room facility	0%	0%
Emergency room professional services	0%	0%
Urgent care center (facility and professional services)	0%	50%

Copayment Exceptions:

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

Note(s):

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

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

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

	Preferred Provider or Emergency Care	Out-of-Network Provider
Ground ambulance	0%	Payable at the Preferred Provider level of benefits
Air ambulance	0%	Payable at the Preferred Provider level of benefits

Note(s):

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

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

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

Ambulance Services (Mental Health and Substance Use Disorders)

	Preferred Provider or Emergency Care	Out-of-Network Provider
Ground ambulance	0%	Payable at the Preferred Provider level of benefits

	Preferred Provider or Emergency Care	Out-of-Network Provider
Air ambulance	0%	Payable at the Preferred Provider level of benefits

Note(s):

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

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

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

Office Visits

	Preferred Provider	Out-of-Network Provider
Visit to Physician, Physician Assistant, Nurse Practitioner, or Podiatrist	0%	50%
Specialist consultation	0%	50%
Physician visit to Member's home	0%	50%
Specialist visit to Member's home	0%	50%
Annual physical examination*	Not covered	Not covered
Vision examination for diagnosis or treatment, including refractive eye examinations (age 19 and older) by an ophthalmologist**	0%	Not covered
Vision examination for diagnosis or treatment, including refractive eye examinations (age 19 and older) by all other providers including optometrists**	0%	Not covered

	Preferred Provider	Out-of-Network Provider
Hearing examination (for diagnosis or treatment)	0%	Not covered
Telehealth consultation through the Select Telehealth Services Provider***	0%	Not covered

Note(s):

* For nonpreventive purposes, 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.

** From birth to age 19, see "Pediatric Vision Services" for details regarding pediatric vision care services.

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

Preventive Care Services

	Preferred Provider	Out-of-Network Provider
Preventive Care Services*	$0, Deductible waived	Not covered

Note(s):

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

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

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

Hospital Visits by Physician

	Preferred Provider	Out-of-Network Provider
Physician visit to Hospital or Skilled Nursing Facility	0%	50%

Note(s):

The above Copayment or Coinsurance applies to professional services only. Care that is rendered in a Hospital or Skilled Nursing Facility is also subject to the applicable facility Copayment or

Coinsurance. Look under the “Inpatient Hospital Services” and “Skilled Nursing Facility Services” headings to determine any additional Copayments or Coinsurance that may apply.

Allergy, Immunizations and Injections

	Preferred Provider	Out-of-Network Provider
Allergy testing	0%	50%
Allergy injection services (serum not included)	0%	50%
Allergy serum	0%	50%
Immunizations for occupational purposes or foreign travel	Not covered	Not covered
Injections (except for Infertility) Office-based injectable medications (per dose)	0%	50%

Note(s):

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

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

Rehabilitation and Habilitation Therapy

	Preferred Provider	Out-of-Network Provider
Physical therapy, speech therapy, occupational therapy, habilitation therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation therapy	0%	Not covered

Note(s):

These services will be covered when Medically Necessary.

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

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

Care for Conditions of Pregnancy

	Preferred Provider	Out-of-Network Provider
Prenatal care and preconception visits*	$0, Deductible waived	50%
Postnatal office visit*	$0	50%
Newborn care office visit (birth through 30 days)*	0%	50%
Physician visit to the mother or newborn at a Hospital	0%	50%
Normal delivery, including cesarean section	0%	50%
Circumcision of newborn (birth through 30 days)**		
In an inpatient setting	0%	50%
In a Physician’s office or outpatient facility	0%	50%

Note(s):

The above Copayments and Coinsurances apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment or Coinsurance. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional Copayments or Coinsurance that may apply. Genetic testing is covered as a laboratory service as shown under the “Other Professional Services” heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.

* After the Calendar Year Deductible has been met, termination of pregnancy and related services are covered in full. Prenatal, postnatal, and newborn care that are Preventive Care Services are covered in full under Preferred Providers and the Calendar Year Deductible does not apply. See “Preventive Care Services” above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to “Preventive Care Services” and “Pregnancy” in the “Covered Services and Supplies” section.

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

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

Family Planning

	Preferred Provider	Out-of-Network Provider
Sterilization of female	$0, Deductible waived	Not covered
Sterilization of male	$0*	50%

Note(s):

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

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

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

* $0 after reaching the Internal Revenue Service minimum deductible amounts for High Deductible Health Plans (HDHP) of $1,650 for subscriber-only coverage or $3,300 for family coverage. This is not an additional deductible but a requirement to meet this portion of your annual Deductible before this service is covered at $0.

Other Professional Services

	Preferred Provider	Out-of-Network Provider
Surgery or assistance at surgery Performed in an office or outpatient facility	0%	50%
Surgery or assistance at surgery Performed in an inpatient setting	0%	50%
Administration of anesthetics Performed in an office or outpatient facility	0%	50%
Administration of anesthetics Performed in an inpatient setting	0%	50%
Chemotherapy	0%	50%
Radiation therapy	0%	50%
Laboratory tests	0%	50%
Diagnostic imaging (including x-ray)	0%	50%

	Preferred Provider	Out-of-Network Provider
Complex radiology (CT, SPECT, MRI, MUGA and PET)	0%	50%
Medical social services	0%	Not covered
Patient education*	$0, Deductible waived	50%
Nuclear medicine (use of radioactive materials)		
In an inpatient setting	0%	50%
In a Physician's office or outpatient facility	0%	50%
Renal dialysis		
In an inpatient setting	0%	50%
In a Physician's office or outpatient facility	0%	50%
Organ, tissue or stem cell transplants**	See note below	Not covered
Infusion therapy in an office, outpatient, or home setting	0%	Not covered

Note(s):

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

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

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

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

** Applicable Deductible, Copayment and Coinsurance requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment or Coinsurance will apply. Refer to the "Organ, Tissue and Stem Cell Transplants" portion of the "Covered Services and Supplies" section for details.

Medical Supplies

	Preferred Provider	Out-of-Network Provider
Durable Medical Equipment, nebulizers, including face masks and tubing*	0%	Not covered
Orthotics (such as bracing, supports and casts)	0%	50%
Diabetic equipment, including diabetic footwear**	0%	50%
Prostheses (internal or external)***	0%	50%
Blood or blood products except for drugs used to treat hemophilia, including blood factors****	0%	50%
Wigs (cranial prostheses)*****	0%	50%

Note(s):

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

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

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

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

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

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

*****Wigs (cranial prostheses) following chemotherapy and/or radiation therapy services, burns or for Members who suffer from alopecia are covered and are subject to one wig per year maximum. No other coverage will be provided for wigs. Hair transplantation, hair analysis and hairpieces are not covered.

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

Home Health Care Services

	Preferred Provider	Out-of-Network Provider
Home health visit	0%	Not covered
Calendar Year maximum	*100 visits*	*Not Applicable*

Note(s):

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

Hospice Services

	Preferred Provider	Out-of-Network Provider
Hospice care	0%	50%

Note(s):

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

Inpatient Hospital Services

	Preferred Provider	Out-of-Network Provider
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services	0%	50%

Note(s):

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

Sterilization provided by a Preferred Provider at an in-network Hospital or outpatient facility are not subject to Copayments or Coinsurance after the minimum deductible is met as described in the "Family Planning" provision above.

The above cost-sharing amounts apply to the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Coinsurance for inpatient Hospital services unless the newborn patient requires admission

to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.

The Preferred Provider Deductible and Coinsurance will apply if you are admitted to a Hospital directly from an emergency room or urgent care center. You will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider.

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

Services for bariatric surgery and organ, tissue and stem cell transplants by Out-of-Network Providers are not covered.

Outpatient Facility Services

	Preferred Provider	Out-of-Network Provider
Outpatient surgery (Hospital or Outpatient Surgical Center)	0%	50%
Outpatient services (other than surgery, except for Infertility services)	0%	50%

Note(s):

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

Sterilization provided by a Preferred Provider at an in-network Hospital or outpatient facility are not subject to Copayments or Coinsurance after the minimum deductible is met as described in the "Family Planning" provision above.

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services or physical therapy are subject to the same Copayment or Coinsurance that is required when these services are performed at your Physician’s office. Look under the headings for the various services such as office visits, rehabilitation, and other professional services to determine any additional Copayment or Coinsurance payments that may apply.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above.

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

Skilled Nursing Facility Services

	Preferred Provider	Out-of-Network Provider
Room and board in a semiprivate room with ancillary (additional) services	0%	50%
Combined Calendar Year maximum	*100 days*	*100 days*

Note(s):

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

Mental Health and Substance Use Disorders

Mental Health and Substance Use Disorders

	Preferred Provider	Out-of-Network Provider
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	0%	50%
Outpatient group therapy session*	0%	50%
Outpatient services other than office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization, and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	0%	50%
Mental health professional visit to Members home (at the discretion of the mental health professional)	0%	50%

	Preferred Provider	Out-of-Network Provider
Mental health professional visit to Hospital, behavioral health facility or Residential Treatment Center	0%	50%
Inpatient services at a Hospital, behavioral health facility or Residential Treatment Center**	0%	50%
Inpatient detoxification	0%	50%

Note(s):

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

Exception(s):

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

* Each group therapy session counts as one half of a private office visit for each Member participating in the session.

** Inpatient visits by Participating Mental Health Professionals other than Physicians are included in the inpatient services facility fee.

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

Prescription Drugs

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed, and whether the drug was dispensed by a Participating Pharmacy or a Nonparticipating Pharmacy as defined in the "Definitions" section. Also refer to Notes below for clarification regarding Deductible, Copayment, Coinsurance, and any applicable Coinsurance maximum or benefit maximums.

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

Prescription Drug Deductible

The outpatient Prescription Drug benefits are subject to the Calendar Year Deductibles as described at the beginning of this “Schedule of Benefits” section.

Copayment and Coinsurance

Retail Pharmacy (up to a 30-day supply)	Participating Pharmacy	Nonparticipating Pharmacy
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	0%	Not covered
Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs, and any other drugs recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost	0%	Not covered
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier	0%	Not covered
Preventive drugs and contraceptives	$0, Deductible waived	Not covered

Tier 4 (Specialty Drugs) (up to a 30-day supply)	Specialty Pharmacy Vendor
Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply	0%

Maintenance Drugs through the Mail Order Program (up to a 90-day supply)	Mail Order Program
Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs	0%
Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs, and any other drugs recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost	0%
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier	0%
Preventive drugs and contraceptives	$0, Deductible waived

Note(s):

You will be charged the applicable Copayment or Coinsurance for each Prescription Drug Order. The Coinsurance listed above is based on the Prescription Drug Covered Expense.

To obtain specific benefit and drug information, including your cost for a specific drug at your preferred pharmacy, please log into your secure Member portal or call the Customer Contact Center at the number on your Health Net ID card.

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

*Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of **$250** for an individual prescription of up to a 30-day supply*.

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 at the Copayment for Tier 3 Drugs or Specialty Drugs.

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

Prior Authorization:

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

Copayment Exception(s):

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

Preventive Drugs and Contraceptives:

Preventive drugs, including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration and recommended by the United States Preventive Services Task Force (USPSTF) are covered at no cost to the Member, and are not subject to the Deductible. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section for additional details. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications.

Generic Drugs will be dispensed when a Generic Drug equivalent is available. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

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

Mail Order:

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

Diabetic Supplies:

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

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

Tier 4 Drugs (Specialty Drugs):

Tier 4 Drugs (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 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 Drugs (Specialty Drugs) are identified in the Essential

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 Drugs (Specialty Drugs) are not available through mail order.

Pediatric Dental Services

Refer to the "Pediatric Dental Services" portion of the "Covered Services and Supplies" section of this *Plan Contract and Evidence of Coverage* for complete benefit information.

All of the following services must be provided by a Health Net participating dental provider in order to be covered. Refer to the "Pediatric Dental Services" portion of the "Exclusions and Limitations" section for additional limitations on covered 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 noncovered 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 Contract*, a participating dental provider may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not covered benefits, 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 member services at **(866) 249-2382** or your insurance broker. To fully understand your coverage, you may wish to carefully review this *Plan Contract*.

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.

Benefit Description

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Code	Service	Member cost share
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
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

Code	Service	Member cost share
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays Intraoral - comprehensive 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
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

Code	Service	Member cost share
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
D0396	3D printing of a 3D dental surface scan	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
D0701	Panoramic radiographic image - image capture only	No Charge
D0702	2-D cephalometric radiographic image - image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image - image capture only	No Charge
D0706	Intraoral - occlusal radiographic image - image capture only	No Charge
D0707	Intraoral - periapical radiographic image - image capture only	No Charge
D0708	Intraoral - bitewing radiographic image - image capture only	No Charge
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Charge
D0801	3D dental surface scan - direct	No Charge
D0802	3D dental surface scan - indirect	No Charge
D0803	3D facial surface scan - direct	No Charge
D0804	3D facial surface scan - indirect	No Charge

Code	Service	Member cost share
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
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No Charge
D1330	Oral hygiene instructions	No Charge
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
D1355	Caries preventive 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

Code	Service	Member cost share
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Charge
D1553	Re-cement or re-bond unilateral 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	20%
D2140	Amalgam - one surface, permanent limited to once in a 36-month period	20%
D2150	Amalgam - two surfaces, primary limited to once in a 12-month period	20%
D2150	Amalgam - two surfaces, permanent limited to once in a 36-month period	20%
D2160	Amalgam - three surfaces, primary limited to once in a 12-month period	20%
D2160	Amalgam - three surfaces, permanent limited to once in a 36-month period	20%
D2161	Amalgam - four or more surfaces, primary limited to once in a 12-month period	20%
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36-month period	20%
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12-month period	20%
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36-month period	20%
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12-12month period	20%
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36-month period	20%

Code	Service	Member cost share
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12-month period	20%
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36-month period	20%
D2335	Resin-based composite - four or more surfaces (anterior) primary limited to once in a 12-month period	20%
D2335	Resin-based composite - four or more surfaces (anterior) permanent limited to once in a 36-month period	20%
D2390	Resin-based composite crown, anterior, primary limited to once in a 12-month period	20%
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36-month period	20%
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12-month period	20%
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36-month period	20%
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12-month period	20%
D2392	Resin-based composite - two surfaces, posterior; permanent limited to once in a 36-month period	20%
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12-month period	20%
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36-month period	20%
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12-month period	20%
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36-month period	20%
D2710	Crown - Resin-based composite (indirect) limited to once in a 5-year period	20%
D2712	Crown - ¾ resin-based composite (indirect) limited to once in a 5-year period	20%
D2721	Crown - Resin with predominantly base metal limited to once in a 5-year period	20%
D2740	Crown - porcelain/ceramic limited to once in a 5-year period	20%

Code	Service	Member cost share
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5-year period	20%
D2781	Crown - ¾ cast predominantly base metal limited to once in a 5-year period	20%
D2783	Crown - ¾ porcelain/ceramic limited to once in a 5-year period	20%
D2791	Crown - full cast predominantly base metal limited to once in a 5-year period	20%
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period	20%
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	20%
D2920	Recement or re-bond crown	20%
D2921	Reattachment of tooth fragment, incisal edge, or cusp	20%
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	20%
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12-month period	20%
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12-month period	20%
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36-month period	20%
D2932	Prefabricated Resin Crown, primary limited to once in a 12-month period	20%
D2932	Prefabricated Resin Crown, permanent limited to once in a 36-month period	20%
D2933	Prefabricated Stainless steel crown with resin window, primary limited to one in a 12-month period	20%
D2933	Prefabricated Stainless steel crown with resin window, permanent limited to once in a 36-month period	20%
D2940	Protective restoration limited to once per tooth in a 12-month period	20%
D2941	Interim therapeutic restoration - primary dentition	20%
D2949	Restorative foundation for an indirect restoration	20%
D2950	Core buildup, including any pins when required	20%
D2951	Pin retention - per tooth, in addition to restoration	20%

Code	Service	Member cost share
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	20%
D2953	Each additional indirectly fabricated post - same tooth	20%
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	20%
D2955	Post removal	20%
D2957	Each additional prefabricated post - same tooth	20%
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework	20%
D2976	Band stabilization – per tooth	20%
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.	20%
D2989	Excavation of a tooth resulting in the determination of non-restorability	20%
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No Charge
D2999	Unspecified restorative procedure, by report	20%
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	50%
D3120	Pulp cap - indirect (excluding final restoration)	50%
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	50%
D3221	Pupal debridement primary and permanent teeth	50%
D3222	Partial Pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	50%
D3230	Pulpal therapy (resorbable filing) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%
D3240	Pulpal therapy (resorbable filing) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	50%

Code	Service	Member cost share
D3310	Endodontic (Root canal) therapy, Anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3320	Endodontic (Root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3330	Endodontic (Root canal) therapy, Molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	50%
D3331	Treatment of root canal obstruction; nonsurgical access	50%
D3333	Internal root repair of perforation defects	50%
D3346	Retreatment of previous root canal therapy - anterior	50%
D3347	Retreatment of previous root canal therapy - premolar	50%
D3348	Retreatment of previous root canal therapy - molar	50%
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	50%
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth	50%
D3410	Apicoectomy - anterior	50%
D3421	Apicoectomy - premolar (first root)	50%
D3425	Apicoectomy - molar (first root)	50%
D3426	Apicoectomy (each additional root)	50%
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	50%
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	50%
D3430	Retrograde filling - per root	50%
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	50%
D3471	Surgical repair of root resorption - anterior	50%
D3472	Surgical repair of root resorption - premolar	50%
D3473	Surgical repair of root resorption - molar	50%
D3910	Surgical procedure for isolation of tooth with rubber dam	50%

Code	Service	Member cost share
D3999	Unspecified endodontic procedure, by report	50%
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - once per quadrant every 36 months	50%
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	50%
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	50%
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	50%
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	50%
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	50%
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	50%
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%
D4910	Periodontal maintenance limited to once in a calendar quarter	20%
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).	50%
D4999	Unspecified periodontal procedure, by report	50%

Code	Service	Member cost share
Prosthodontics, removable		
D5110	Complete denture - maxillary limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	50%
D5120	Complete denture - mandibular limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	50%
D5130	Immediate denture - maxillary	50%
D5140	Immediate denture - mandibular	50%
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	50%
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	50%
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	50%
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	50%
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	50%
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	50%
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12-month period	50%
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12-month period	50%
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12-month period	50%

Code	Service	Member cost share
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12-month period	50%
D5511	Repair broken complete denture base, mandibular	50%
D5512	Repair broken complete denture base, maxillary	50%
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	50%
D5611	Repair resin denture base, mandibular	50%
D5612	Repair resin denture base, maxillary	50%
D5621	Repair cast framework, mandibular	50%
D5622	Repair cast framework, maxillary	50%
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	50%
D5650	Add tooth to existing partial denture limited to a maximum of three, per date of service; once per tooth	50%
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	50%
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period	50%
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period	50%
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period	50%
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period	50%
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period	50%
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period	50%
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period	50%

Code	Service	Member cost share
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period	50%
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period	50%
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.	50%
D5862	Precision attachment, by report	50%
D5863	Overdenture - complete maxillary	50%
D5864	Overdenture - partial maxillary	50%
D5865	Overdenture - complete mandibular	50%
D5866	Overdenture - partial mandibular	50%
D5899	Unspecified removable prosthodontic procedure, by report	50%
Maxillofacial Prosthetics		
D5911	Facial moulage (sectional)	50%
D5912	Facial moulage (complete)	50%
D5913	Nasal prosthesis	50%
D5914	Auricular prosthesis	50%
D5915	Orbital prosthesis	50%
D5916	Ocular prosthesis	50%
D5919	Facial prosthesis	50%
D5922	Nasal septal prosthesis	50%
D5923	Ocular prosthesis, interim	50%
D5924	Cranial prosthesis	50%
D5925	Facial augmentation implant prosthesis	50%
D5926	Nasal prosthesis, replacement	50%
D5927	Auricular prosthesis, replacement	50%
D5928	Orbital prosthesis, replacement	50%

Code	Service	Member cost share
D5929	Facial prosthesis, replacement	50%
D5931	Obturator prosthesis, surgical	50%
D5932	Obturator prosthesis, definitive	50%
D5933	Obturator prosthesis, modification limited to twice in a 12-month period	50%
D5934	Mandibular resection prosthesis with guide flange	50%
D5935	Mandibular resection prosthesis without guide flange	50%
D5936	Obturator prosthesis, interim	50%
D5937	Trismus appliance (not for TMD treatment)	50%
D5951	Feeding aid	50%
D5952	Speech aid prosthesis, pediatric	50%
D5953	Speech aid prosthesis, adult	50%
D5954	Palatal augmentation prosthesis	50%
D5955	Palatal lift prosthesis, definitive	50%
D5958	Palatal lift prosthesis, interim	50%
D5959	Palatal lift prosthesis, modification limited to twice in a 12-month period	50%
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period	50%
D5982	Surgical stent	50%
D5983	Radiation carrier	50%
D5984	Radiation shield	50%
D5985	Radiation cone locator	50%
D5986	Fluoride gel carrier	50%
D5987	Commissure splint	50%
D5988	Surgical splint	50%
D5991	Vesiculobullous disease medicament carrier	50%
D5999	Unspecified maxillofacial prosthesis, by report	50%
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	50%

Code	Service	Member cost share
D6011	Surgical access to an implant body (second stage implant surgery)	50%
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	50%
D6013	Surgical placement of mini-implant	50%
D6040	Surgical placement: eposteal implant	50%
D6050	Surgical placement: transosteal implant	50%
D6055	Connecting bar - implant supported or abutment supported	50%
D6056	Prefabricated abutment - includes modification and placement	50%
D6057	Custom fabricated abutment - includes placement	50%
D6058	Abutment supported porcelain/ceramic crown	50%
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	50%
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	50%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	50%
D6062	Abutment supported cast metal crown (high noble metal)	50%
D6063	Abutment supported cast metal crown (predominantly base metal)	50%
D6064	Abutment supported cast metal crown (noble metal)	50%
D6065	Implant supported porcelain/ceramic crown	50%
D6066	Implant supported crown (porcelain fused to high noble alloys)	50%
D6067	Implant supported crown (high noble alloys)	50%
D6068	Abutment supported retainer for porcelain/ceramic FPD	50%
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	50%
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	50%
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	50%
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	50%

Code	Service	Member cost share
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	50%
D6074	Abutment supported retainer for cast metal FPD (noble metal)	50%
D6075	Implant supported retainer for ceramic FPD	50%
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	50%
D6077	Implant supported retainer for metal FPD (high noble alloys)	50%
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	50%
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	50%
D6082	Implant supported crown - porcelain fused to predominantly base alloys	50%
D6083	Implant supported crown - porcelain fused to noble alloys	50%
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	50%
D6085	Interim implant crown	50%
D6086	Implant supported crown - predominantly base alloys	50%
D6087	Implant supported crown - noble alloys	50%
D6088	Implant supported crown - titanium and titanium alloys	50%
D6089	Accessing and retorquing loose implant screw – per screw	50%
D6090	Repair implant supported prosthesis, by report	50%
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	50%
D6092	Recement implant/abutment supported crown	50%
D6093	Recement implant/abutment supported fixed partial denture	50%
D6094	Abutment supported crown - titanium and titanium alloys	50%
D6095	Repair implant abutment, by report	50%
D6096	Removal of broken implant retaining screw	50%

Code	Service	Member cost share
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	50%
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	50%
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	50%
D6100	Surgical removal of implant body	50%
D6105	Removal of implant body not requiring bone removal or flap elevation	50%
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	50%
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	50%
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	50%
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	50%
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	50%
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	50%
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	50%
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	50%
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	50%
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	50%
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	50%
D6121	Implant supported retainer for metal FPD - predominantly base alloys	50%
D6122	Implant supported retainer for metal FPD - noble alloys	50%
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	50%
D6190	Radiographic/Surgical implant index, by report	50%

Code	Service	Member cost share
D6191	Semi-precision abutment - placement	50%
D6192	Semi-precision attachment - placement	50%
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	50%
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	50%
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	50%
D6198	Remove interim implant component	50%
D6199	Unspecified implant procedure, by report	50%
Prosthodontics, fixed		
D6211	Pontic - cast predominantly base metal limited to once in a 5-year period	50%
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5-year period	50%
D6245	Pontic - porcelain/ceramic limited to once in a 5-year period	50%
D6251	Pontic - resin with predominantly base metal limited to once in a 5-year period	50%
D6721	Retainer Crown - resin predominantly base metal - denture limited to once in a 5-year period	50%
D6740	Retainer Crown - porcelain/ceramic limited to once in a 5-year period	50%
D6751	Retainer Crown - porcelain fused to predominantly base metal limited to once in a 5-year period	50%
D6781	Retainer Crown - ¾ cast predominantly base metal limited to once in a 5-year period	50%
D6783	Retainer Crown - ¾ porcelain/ceramic limited to once in a 5-year period	50%
D6784	Retainer Crown - ¾ titanium and titanium alloys	50%
D6791	Retainer Crown - full cast predominantly base metal limited to once in a 5-year period	50%
D6930	Recement or re-bond fixed partial denture	50%

Code	Service	Member cost share
D6980	Fixed partial denture repair necessitated by restorative material failure	50%
D6999	Unspecified fixed prosthodontic procedure, by report	50%
Oral Maxillofacial Prosthetics		
D7111	Extraction, coronal remnants - primary tooth	50%
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	50%
D7220	Removal of impacted tooth - soft tissue	50%
D7230	Removal of impacted tooth - partially bony	50%
D7240	Removal of impacted tooth - completely bony	50%
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	50%
D7250	Removal of residual tooth roots (cutting procedure)	50%
D7260	Oroantral fistula closure	50%
D7261	Primary closure of a sinus perforation	50%
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	50%
D7280	Exposure of an unerupted tooth	50%
D7283	Placement of device to facilitate eruption of impacted tooth	50%
D7284	Excisional biopsy of minor salivary glands	50%
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	50%
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	50%
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	50%

Code	Service	Member cost share
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	50%
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.	50%
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	50%
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	50%
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) limited to once in a 5-year period per arch	50%
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	50%
D7410	Excision of benign lesion up 1.25 cm	50%
D7411	Excision of benign lesion greater than 1.25 cm	50%
D7412	Excision of benign lesion, complicated	50%
D7413	Excision of malignant lesion up to 1.25 cm	50%
D7414	Excision of malignant lesion greater than 1.25 cm	50%
D7415	Excision of malignant lesion, complicated	50%
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	50%
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	50%
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%

Code	Service	Member cost share
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%
D7465	Destruction of lesion(s) by physical or chemical method, by report	50%
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	50%
D7472	Removal of torus palatinus limited to once in a patient's lifetime	50%
D7473	Removal of torus mandibularis limited to once per quadrant	50%
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	50%
D7490	Radical resection of maxilla or mandible	50%
D7509	Marsupialization of odontogenic cyst	50%
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	50%
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	50%
D7520	Incision and drainage of abscess - extraoral soft tissue	50%
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	50%
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	50%
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone limited to once per quadrant per date of service	50%
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	50%
D7610	Maxilla - open reduction (teeth immobilized, if present)	50%
D7620	Maxilla - closed reduction (teeth immobilized, if present)	50%
D7630	Mandible - open reduction (teeth immobilized, if present)	50%

Code	Service	Member cost share
D7640	Mandible - closed reduction (teeth immobilized, if present)	50%
D7650	Malar and/or zygomatic arch - open reduction	50%
D7660	Malar and/or zygomatic arch - closed reduction	50%
D7670	Alveolus - closed reduction, may include stabilization of teeth	50%
D7671	Alveolus - open reduction, may include stabilization of teeth	50%
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	50%
D7710	Maxilla - open reduction	50%
D7720	Maxilla - closed reduction	50%
D7730	Mandible - open reduction	50%
D7740	Mandible - closed reduction	50%
D7750	Malar and/or zygomatic arch - open reduction	50%
D7760	Malar and/or zygomatic arch - closed reduction	50%
D7770	Alveolus - open reduction stabilization of teeth	50%
D7771	Alveolus, closed reduction stabilization of teeth	50%
D7780	Facial bones - complicated reduction with fixation and multiple approaches	50%
D7810	Open reduction of dislocation	50%
D7820	Closed reduction of dislocation	50%
D7830	Manipulation under anesthesia	50%
D7840	Condylectomy	50%
D7850	Surgical discectomy, with/without implant	50%
D7852	Disc repair	50%
D7854	Synovectomy	50%
D7856	Myotomy	50%
D7858	Joint reconstruction	50%
D7860	Arthrotomy	50%
D7865	Arthroplasty	50%
D7870	Arthrocentesis	50%
D7871	Non-arthroscopic lysis and lavage	50%

Code	Service	Member cost share
D7872	Arthroscopy - diagnosis, with or without biopsy	50%
D7873	Arthroscopy - lavage and lysis of adhesions	50%
D7874	Arthroscopy - disc repositioning and stabilization	50%
D7875	Arthroscopy - synovectomy	50%
D7876	Arthroscopy - discectomy	50%
D7877	Arthroscopy - debridement	50%
D7880	Occlusal orthotic device, by report	50%
D7881	Occlusal orthotic device adjustment	50%
D7899	Unspecified TMD therapy, by report	50%
D7910	Suture of recent small wounds up to 5 cm	50%
D7911	Complicated suture - up to 5 cm	50%
D7912	Complicated suture - greater than 5 cm	50%
D7920	Skin graft (identify defect covered, location and type of graft)	50%
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	50%
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	50%
D7940	Osteoplasty - for orthognathic deformities	50%
D7941	Osteotomy - mandibular rami	50%
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	50%
D7944	Osteotomy - segmented or subapical	50%
D7945	Osteotomy - body of mandible	50%
D7946	LeFort I (maxilla - total)	50%
D7947	LeFort I (maxilla - segmented)	50%
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	50%
D7949	LeFort II or LeFort III - with bone graft	50%
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	50%
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	50%

Code	Service	Member cost share
D7952	Sinus augmentation via a vertical approach	50%
D7955	Repair of maxillofacial soft and/or hard tissue defect	50%
D7961	Buccal/labial frenectomy (frenulectomy)	50%
D7962	Lingual frenectomy (frenulectomy)	50%
D7963	Frenuloplasty limited to once per arch per date of service	50%
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	50%
D7971	Excision of pericoronal gingiva	50%
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	50%
D7979	Non-surgical sialolithotomy	50%
D7980	Surgical sialolithotomy	50%
D7981	Excision of salivary gland, by report	50%
D7982	Sialodochoplasty	50%
D7983	Closure of salivary fistula	50%
D7990	Emergency tracheotomy	50%
D7991	Coronoidectomy	50%
D7995	Synthetic graft - mandible or facial bones, by report	50%
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	50%
D7999	Unspecified oral surgery procedure, by report	50%
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.)	50%
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	
D8670	Periodic orthodontic treatment visit	

Code	Service	Member cost share
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 treatment of dental Pain - per visit	50%
D9120	Fixed partial denture sectioning	50%
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	50%
D9211	Regional block anesthesia	50%
D9212	Trigeminal division block anesthesia	50%
D9215	Local anesthesia in conjunction with operative or surgical procedures	50%
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	50%
D9222	Deep sedation/general anesthesia - first 15 minutes	50%
D9223	Deep sedation/general anesthesia - each subsequent 15-minute increment	50%
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	50%
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	50%
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15-minute increment	50%

Code	Service	Member cost share
D9248	Non-intravenous conscious sedation	50%
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician	50%
D9311	Consultation with a medical health professional	No charge
D9410	House/Extended care facility call	50%
D9420	Hospital or ambulatory surgical center call	50%
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	50%
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	50%
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	50%
D9612	Therapeutic parenteral drug, two or more administrations, different medications	50%
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	50%
D9930	Treatment of complications - post surgery, unusual circumstances, by report limited to once per date of service	50%
D9950	Occlusion analysis - mounted case limited to once in a 12-month period	50%
D9951	Occlusal adjustment - limited. Limited to once in a 12-month period per quadrant	50%
D9952	Occlusal adjustment - complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)	50%
D9995	Teledentistry - synchronous; real-time encounter. Limited to twice in a 12-month period.	No charge
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review. Limited to twice in a 12-month period.	No charge
D9997	Dental case management - patients with special health care needs	No charge
D9999	Unspecified adjunctive procedure, by report	No charge

Pediatric Vision Services

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your vision office. Customer Service can be reached Monday through Friday at **(866) 392-6058 from 5:00 a.m. to 8:00 p.m.** Pacific Standard Time. Automated service is also provided after hours for eligibility verification and vision office transfers.

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 the "Exclusions and Limitations" section for limitations on covered vision services.

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

Vision Services Benefits

Routine eye exam limit, including Medically Necessary dilation: 1 per Calendar Year ..... $0 Copayment, Deductible waived

Exam options:

- Standard contact lens fit including follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions)
- Premium contact lens fit including follow-up visit (more complex applications, including, but not limited to, toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)

Lenses limit: 1 pair per Calendar Year ..... $0 Copayment, Deductible waived

Including:

- Single vision, bifocal, trifocal, lenticular
- Glass, or plastic, including polycarbonate
- Oversized and glass-grey #3 prescription sunglass lenses

Provider selected frames limit: 1 per Calendar Year ..... $0 Copayment, Deductible waived

Optional lenses and treatments ..... $0 Copayment, Deductible waived

Including:

- UV treatment
- Tint (fashion & gradient & glass-grey)
- Standard plastic scratch coating
- Photochromic/transitions plastic
- Standard, premium and ultra anti-reflective coating
- Polarized
- Standard, premium, select, and ultra-progressive lens
- Hi-Index lenses
- Blended segment lenses
- Intermediate vision lenses
- Select or ultra-progressive lenses

Premium progressive Lenses ..... $0 Copayment, Deductible waived

Provider selected contact lenses are covered, based upon the type of contact lenses selected, every Calendar Year (in lieu of eyeglass lenses) ..... $0 Copayment, Deductible waived

- Standard (hard) contacts 1 contact per eye per every 12 months
- Monthly contacts (six-month supply) 6 lenses per eye
- Bi-weekly (three-month supply) 6 lenses per eye
- Dailies (one-month supply) 30 lenses per eye (60 lenses)
- Medically Necessary[1]

Subnormal or low vision services and aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers, or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years) ..... $0 Copayment, Deductible waived

[1] **Medically Necessary Contact Lenses:**

Contact lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary contact lenses are dispensed in lieu of other eyewear.

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

	Contracted Provider	Out-of-Network Provider
New patient examination	0%	Not covered
Each subsequent visit	0%	Not covered
Re-examination visit	0%	Not covered
Second opinion	0%	Not covered

Note(s):

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

Limitations:

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

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

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

The OOPM amounts for the medical benefits and Prescription Drug benefits are:

Subscriber-only Coverage:

	Preferred Provider	Out-of-Network Provider
Individual OOPM	$6,650	$25,000

Family Coverage:

The following OOPM amounts apply to the Subscriber and Family Members who are covered under this *Plan Contract and Evidence of Coverage* as a family unit. They do not apply to Subscriber-only coverage. The Member must meet the Individual OOPM before benefits are payable. All amounts applied toward the Individual OOPM for each Member in a family unit will accumulate to meet the family OOPM. Once the family OOPM is met, no further Individual OOPM amounts for Members in the family unit will have to be satisfied during that Calendar Year.

	Preferred Provider	Out-of-Network Provider
Individual OOPM	$6,650	$25,000
Family OOPM	$13,300	$50,000

Exceptions to OOPM

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

- Nonauthorization penalties paid for services which were not authorized as required.
- Charges billed in excess of Covered Expenses (Maximum Allowable Amounts) for the services of Out-of-Network Providers.
- Cost sharing paid on your behalf for Prescription Drugs obtained by you through the use of a drug discount, coupon, or copay card provided by a Prescription Drug manufacturer will not apply toward your Out-of-Pocket Maximum. Only what you actually pay will accrue towards your Out-of-Pocket Maximum.

How the OOPM Works

- Any Deductible, Copayments or Coinsurance paid for the services of a Preferred Provider will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductible, Copayments or Coinsurance paid for the services of an Out-of-Network Provider will **not** apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for out-of-network Emergency Care (including emergency medical transportation, emergency Hospital care) and urgent care received outside the United States will be applied to the Out-of-Pocket Maximum for Preferred Providers.
- If the Subscriber has subscriber-only coverage and changes to family coverage (that is, adds Family Members, such as a newborn child), any amounts applied to the individual Out-of-Pocket Maximum for subscriber-only coverage will be applied to the individual and Family Out-of-Pocket Maximum for family coverage.
- If the Subscriber has family coverage and changes to subscriber-only coverage (that is, removes all Family Members), any amounts applied to the individual Out-of-Pocket Maximum for family coverage will be applied to the individual Out-of-Pocket Maximum for subscriber-only coverage.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also 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

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 Ambetter PPO 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 (except for Dependent parents/stepparents as described below); (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 the "Definitions" section.)
- Children: The children of the Subscriber or their spouse (including legally adopted children, stepchildren, and children for whom the Subscriber is a court-appointed guardian).
- A parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Ambetter PPO Service Area.

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 becomes 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/stepparent-child relationship (see "Who is Eligible and How to Enroll for Coverage" section).

- 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 their 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.
- Gain access to the Individual Coverage Health Reimbursement Arrangement (ICHRA) and are not already covered by the ICHRA.
- Were not provided timely notice of an event that triggers eligibility for a special enrollment period.

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 nonpayment 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 Plan.
- 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.
- Enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the COBRA continuation coverage or government subsidies completely ceased.

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 they remain 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 Ambetter PPO Service Area. You should direct any such correspondence to Covered California at: Covered CA, P.O. Box 989725, West Sacramento, CA 95798.

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 their 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.

Dependent Parent/Stepparent: If you have a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Health Net Ambetter PPO Service Area, they may be eligible for coverage under this Plan. You may apply to enroll your Dependent parent/stepparent within 60 days of the qualifying event by submitting a new enrollment application to Covered California. If your Dependent parent/stepparent 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 their spouse will automatically be covered for 31 days (including the date of birth). They are covered for only the 31 days starting on and including the day of birth if you do not enroll the newborn within 31 days (including the date 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 (including the date of birth), your child will be eligible to enroll under a special enrollment period within 60 days of birth. NOTE: This provision does not amend the *Plan Contract and EOC* to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. For more information, please refer to the "Surrogacy Arrangements" portion of the "Exclusions and Limitations" section and the "Surrogacy Arrangements" portion of the "General Provisions" 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. 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.

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. Coverage will begin on the first day of the month after Health Net receives the enrollment request.

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. 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.

Special Reinstatement Rule for Reservists Returning from Active Duty

Reservists ordered to active duty on or after January 1, 2007, who were covered under this Plan at the time they were ordered to active duty and their eligible Dependents will be reinstated without waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty pursuant to Public Law 107-243 or Presidential Order No. 13239. Please notify Covered California when you return from active duty if you want to reinstate your coverage under this Plan.

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.

Re-enrollment

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

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 the "Subscription Charges" section. See the "Subscription Charges" section 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 ID card (or letting someone else use it)
- Termination of this *Plan Contract* for good cause. Termination will be effective as noted below:
    a. Except for no longer residing in the Health Net Ambetter PPO 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 for Coverage" earlier in this section for eligibility provisions.
    b. Except for no longer residing in the Health Net Ambetter PPO 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 Health Net Ambetter PPO 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*.

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*.

PRIOR AUTHORIZATION REQUIREMENT

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

Prior Authorizations are performed by Health Net or an authorized designee. The telephone number which you can use to obtain Prior Authorization is listed on your Health Net ID card. For additional information regarding Prior Authorization requirements for Mental Health and Substance Use Disorders, see the "Mental Health and Substance Use Disorder Benefits" portion of "Covered Services and Supplies."

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

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

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

Services Requiring Prior Authorization

Inpatient admissions

Any type of facility including, but not limited to:

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

Outpatient procedures, services, or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
- Acupuncture (after the initial consultation, continued treatment plans may need approval from ASH)
- Ambulance: nonemergency, air or ground ambulance services
- Bariatric procedures
- Bronchial thermoplasty

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

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

- Neuro or spinal cord stimulator
- Neuropsychological testing
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made)
- Pharmaceuticals

1. Outpatient Prescription Drugs
    - Most Specialty Drugs, including self-injectable drugs and hemophilia factors, must have Prior Authorization through the Prescription Drugs benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Essential Drug List to identify which drugs require Prior Authorization. Urgent or emergent drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.
    - Other Prescription Drugs, as indicated in the Essential Drug List, may require Prior Authorization. Refer to the Essential Drug List to identify which drugs require Prior Authorization.
2. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, freestanding infusion center, home infusion, Outpatient Surgical Center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net website, www.myhealthnetca.com, for a list of Physician-administered drugs that require Prior Authorization. Biosimilars are required in lieu of branded drugs, unless Medically Necessary.

- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services, and supplies such as:

1. Bone alteration or reshaping such as osteoplasty
2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate
4. Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection or implants

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

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

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

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

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

Exceptions

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

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

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

Other than Prescription Drugs, services provided pursuant to a CARE agreement or CARE plan approved by a court do not require Prior Authorization. See “Treatment Related to Judicial or Administrative Proceedings” in the “Exclusions and Limitations” section for more information.

Prior Authorization by Health Net may be required for certain drugs. Please refer to “Prior Authorization Process for Prescription Drugs” in the “Prescription Drugs” section. You may refer to our website at www.myhealthnetca.com to review the drugs that require a Prior Authorization as noted in the Essential Drug List.

Prior Authorization Procedure

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

- Five (5) or more business days before the proposed elective admission date or the commencement of treatment, except when due to a medical emergency.
- 72 hours or sooner, taking into account the medical exigencies, for proposed elective services needed urgently.
- In the event of being admitted into a Hospital following outpatient emergency room or urgent care center services for Emergency Care; please notify the Plan of the inpatient admission within 24 hours or as soon as reasonably possible.
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Services are scheduled to begin.

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

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

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

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

Effect on Benefits

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

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

Resolution of Disputes

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

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

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

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

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

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

For illustration purposes only, Out-of-Network Provider: 70% Health Net Payment, 30% Member Coinsurance:

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

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

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

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

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

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

- ***Maximum Allowable Amount for Out-of-Network Emergency Care*** will be a combined calculation of the following, as applicable: (1) the median of the amounts negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method Health Net generally uses to determine payments for Out-of-Network providers, excluding any in-network Deductible, Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance. Emergency Care from an Out-of-Network Provider is subject to the applicable Deductible, Copayment and/or Coinsurance at the Preferred Provider benefit level. You are not responsible for any amount that exceeds MAA for Emergency Care.
- ***Maximum Allowable Amount for nonemergent services at an in-network health facility,*** at which, or as a result of which, you receive nonemergent covered services by an Out-of-Network Provider, the nonemergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including, but not limited to, injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.
- ***Maximum Allowable Amount for pediatric dental services*** is calculated by Health Net based on available data resources of competitive fees in that geographic area and must not exceed the fees that the dental provider would charge any similarly situated payor for the same services for each covered dental service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. Health Net reimburses nonnetwork dental providers at 55% of FAIR Health rates. You must pay the amount by which the nonnetwork provider's billed charge exceeds the eligible dental expense.

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

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("third-party networks"). In the event Health Net contracts with a third-

party network that has a contract with the Out-of-Network Provider, Health Net may, at its option, use the rate agreed to by the third-party network as the Maximum Allowable Amount. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, you will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the out-of-network benefit level.

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

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

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

COVERED SERVICES AND SUPPLIES

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

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

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

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

Medical Services and Supplies

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

Office Visits

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

Preventive Care Services

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

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

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

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The

list of Preventive Care Services is available through https://www.healthcare.gov/preventive-care-benefits/. Examples of Preventive Care Services include, but are not limited to:

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

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

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

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

COVID-19 Outpatient Services

After the Calendar Year Deductible has been met, COVID-19 diagnostic and screening testing, therapeutics, and vaccinations are:

- Covered in full when provided by a Participating Pharmacy within the Ambetter Pharmacy Network or provider within the Ambetter PPO Network. The Calendar Year Deductible will not apply to Preventive Care Services through a Participating Pharmacy or Preferred Provider; or
- Covered at the applicable Member cost share when provided by a Nonparticipating Pharmacy or Out-of-Network Provider.

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

Surgical Services

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

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

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

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

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

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

Gender Affirming Surgery

Medically Necessary gender affirming services, including, but not limited to, mental health evaluation and treatment, pre-surgical and post-surgical hormone therapy, fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy, orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery) for the treatment of gender dysphoria or gender identity

disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

Laboratory and Diagnostic Imaging (including X-ray) Services

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

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

Home Visit

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

Rehabilitation Therapy

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

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

Habilitative Services

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

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

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

Cardiac Rehabilitation Therapy

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

Pulmonary Rehabilitation Therapy

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

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 nonparticipating or Participating Provider subject to the reimbursement guidelines as specified in the law.

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

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

- The National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the federal Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs;
- A cooperative group or center of any of the entities described above;
- 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 requirements of Health Net, including drugs, items, devices, and services that would normally be covered under this *Plan Contract and EOC*, 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.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery, and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures, alpha-fetoprotein testing and genetic testing of the fetus are also covered.

Prenatal diagnostic procedures include services provided by the California Prenatal Screening Program administered by the California Department of Public Health and are covered at no cost to the Member. The California Prenatal Screening Program is a statewide program offered by prenatal care providers to all pregnant individuals in California. Prenatal screening uses a pregnant individual's blood samples to screen for certain birth defects in their fetus. Prenatal screenings must be performed at or through a PNS-contracted lab. Individuals with a fetus found to have an increased chance of one of those birth defects are offered genetic counseling and other follow-up services through state-contracted Prenatal Diagnosis Centers.

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

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

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

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

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

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

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

If you are discharged earlier, your Physician may decide, at their discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope

of practice includes postpartum care and newborn care. Your Physician will not be required to obtain Prior Authorization for this visit.

NOTE: This provision does not amend the *Plan Contract and EOC* to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. For more information, please refer to the "Surrogacy Arrangements" portion of the "Exclusions and Limitations" section and the "Surrogacy Arrangements" portion of the "General Provisions" section.

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

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

Medical Social Services

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

Home Health Care Services

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

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

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

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

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Member, are not covered even if

they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

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

Home Health Care Services by Out-of-Network Providers are not covered.

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 Public Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substances are covered.

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

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

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

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

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

Outpatient infusion therapy by Out-of-Network Providers is not covered.

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 and EOC*, have been met.

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

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

Nonemergency ambulance services are covered when Medically Necessary and when your conditions require 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.

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

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

Hospice Care

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

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

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

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

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, standard curved handle or quad cane and supplies, dry pressure pad for a mattress, compression burn garments, IV pole, tracheostomy tube and supplies, enteral pump and supplies, bone stimulator, cervical traction (over

door), phototherapy blankets for treatment of jaundice in newborns, bracing, supports, casts, nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Member.

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

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. Health Net will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

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

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

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

Durable Medical Equipment provided by an Out-of-Network Provider is not covered.

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 the “Pediatric Vision Services” portion of “Covered Services and Supplies” for coverage details.

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

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

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

Prior Authorization may be required. Please refer to the "Prior Authorization Requirement" section of this *Plan Contract and EOC* for details. Payment of benefits will be subject to the nonauthorization penalty shown in the “Schedule of Benefits” section if Prior Authorization is not obtained for the care.

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 Coinsurance will apply, as shown in the “Schedule of Benefits” section.

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

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

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

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

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

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 prosthesis.

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

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

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

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

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

Ostomy and Urological Supplies

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

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

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

Cranial Prostheses (Wigs)

Cranial Prostheses (wigs) following chemotherapy and/or radiation therapy services, burns or for Members who suffer from alopecia are covered and are subject to the Calendar Year maximum shown in the "Schedule of Benefits" section.

No other coverage will be provided for wigs. Hair transplantation, hair analysis and hairpieces are not covered.

Blood

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

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; 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.

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

Outpatient Hospital Services

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

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

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

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

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

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

Reconstructive Surgery

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

- Improve function; or

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

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

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

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

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

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

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

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.

Telehealth Services

Covered services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as covered services delivered in-person. For supplemental services that may provide telehealth coverage for certain services at a lower cost, see the "Telehealth Consultations Through the Select Telehealth Services

Provider" provision below. Please refer to the "Telehealth Services" definition in the "Definitions" section for more information.

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

Telehealth Consultations Through the Select Telehealth Services Provider

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

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

Prescription Drug Orders received from the Select Telehealth Services Provider or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the "Prescription Drugs" portion of the "Schedule of Benefits" 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 the "Exclusions and Limitations" section.

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

Skilled Nursing Facility

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

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

Surgically Implanted Drugs

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of 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. Preferred Providers that are not designated as part of Health Net's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your Physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time Prior 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, recreation are specifically excluded.

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

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

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment, including refractive eye examinations, are covered as shown in the "Schedule of Benefits" section of this *Plan Contract and EOC*. Preventive vision and hearing screening are covered as Preventive Care Services. See the "Pediatric Vision Services" portion of the "Schedule of Benefits" for information regarding vision examinations for children under 19 years of age.

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

Renal Dialysis

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Self-Referral for Reproductive and Sexual Health Care Services

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

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

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

Immunizations and Injections

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

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

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

Immunizations and injections for foreign travel/occupational purposes are not covered.

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.” Sterilization of females and contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include (IUDs), injectable and implantable contraceptives. Contraceptives that are covered under the pharmacy benefit are 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 the “Schedule of Benefits” section as would be required for covered services to treat any illness or condition under this Plan.

Patient Education

Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered.

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered if the transplant is Prior Authorized by Health Net. Please refer to the "Prior Authorization Requirement" section for information on how to obtain Prior Authorization.

Health Net has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Physician can provide you with information about our Transplant Performance Centers. You will be directed to a designated Health Net Transplant Performance Center at the time authorization or Prior Authorization is obtained. Preferred Providers that are not designated as part of Health Net's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

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

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

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

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

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

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

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

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

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

Acupuncture Services

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

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

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

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

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

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

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.

Mental Health and Substance Use Disorder Benefits

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

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

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

Upon request, the criteria used to review the Prior Authorization request, and any education program materials used to develop these criteria, will be provided to you at no cost. This information is available online at our website www.myhealthnetca.com. You can also call the Health Net Customer Contact Center at the telephone number on your Health Net ID card to request the information.

How to Obtain Care – In Network

When you need to see a Participating Mental Health Professional, contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card. Health Net will help you identify a nearby Participating Mental Health Professional, within the network and with whom you can schedule an appointment, as discussed in the “Introduction to Health Net” section. The designated Participating Mental Health Professional will evaluate you, develop a treatment plan for you, and submit that treatment plan to Health Net for review. Upon review and Prior Authorization (if Prior Authorization is required) by Health Net, the proposed services will be covered by this Plan if they are determined to be Medically Necessary.

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

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

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

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

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

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

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

How to Obtain Care – Out-of-Network

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

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

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

Emergency care services, regardless of whether the Member is admitted, do not require Prior Authorization.

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic Mental Health or Substance Use Disorder condition from a nonparticipating 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 Health Net, subject to applicable Copayments and any other exclusions and limitations of this Plan.

Your nonparticipating mental health professional must be willing to accept Health Net's standard Mental Health and Substance Use Disorder provider contract terms and conditions and be located in the Plan's service area.

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

Covered Services and Supplies

Outpatient Services

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

Covered services include:

- Outpatient office visits/professional consultation including substance use disorders: Includes outpatient crisis intervention, assessment and treatment services, medication management (including detoxification), drug therapy monitoring, and specialized therapy including individual and group mental health evaluation and treatment.
- Outpatient services other than an office visits/professional consultation including substance use disorders: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Health and Substance Use Disorder, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization program. An 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. A partial hospitalization/day treatment program is a treatment program that may be freestanding or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral health treatment for pervasive developmental disorder or autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with pervasive developmental disorder or autism, are covered as shown in "Schedule of Benefits," under "Mental Health and Substance Use Disorders."
    - The treatment must be prescribed by a licensed Physician or a licensed psychologist and must be provided under a documented treatment plan prescribed, developed, and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.

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

Inpatient Services

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

Covered services and supplies include:

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

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

Detoxification and Treatment for Withdrawal Symptoms

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

Other Mental Health and Substance Use Disorders

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

Transitional Residential Recovery Services

Transitional residential recovery services for substance use disorders in a licensed recovery home when approved by Health Net are covered.

Prescription Drugs

Please read the "Prescription Drugs" portion of the "Exclusions and Limitations" section of this *Plan Contract and EOC*.

You must satisfy the Prescription Drug Deductible, if applicable, as shown in the "Schedule of Benefits" section before benefits for Prescription Drugs become payable by Health Net.

Covered Drugs and Supplies

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

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

Tier 1 and Tier 2 Drugs

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs, and Tier 2 Drugs include nonpreferred Brand Name Drugs, preferred Brand Name Drugs and drugs recommended by Health Net's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost.

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

Tier 3 Drugs

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by Health Net's Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

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

Please refer to the "What Is the Health Net Essential Drug List" portion of this section for more details.

Tier 4 Drugs (Specialty Drugs)

Tier 4 Drugs (Specialty Drugs) are drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost Health Net more than six hundred dollars ($600) net of rebates for a one-month supply. Tier 4 Drugs (Specialty Drugs) are identified in the Essential Drug List with "SP." Refer to Health Net's Essential Drug List on our website at www.myhealthnetca.com for the Tier 4 Drugs (Specialty Drugs) listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

All Tier 4 Drugs (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 Drugs (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 Drugs (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. Brand Name Drugs that have generic equivalents will be dispensed when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, subject to the Copayment requirements described in the "Prescription Drugs" portion of the "Schedule of Benefits" section.

Off-Label Drugs

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

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

B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:

   i. The Elsevier Gold Standard's Clinical Pharmacology.

   ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.

   iii. The Thomson Micromedex DrugDex; OR

C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal, 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.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential 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 (including those designed to assist the visually impaired) and test strips, ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section under "Diabetic Equipment" for additional information. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

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

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

Drug List and when there is no similar commercially available product. Coverage for compounded drugs must be obtained from a Participating Pharmacy and is subject to Prior Authorization by the Plan and Medical Necessity. Refer to the "Off-Label Drugs" provision in this "Prescription Drugs" portion of the "Covered Services and Supplies" section for information about FDA-approved drugs for off-label use. Coverage for compounded drugs requires the Tier 3 Drug Copayment must be obtained from a Participating Pharmacy and is subject to Prior Authorization by the Plan and Medical Necessity. If the compounded drug contains a Tier 4 Drug (Specialty Drugs), the Copayment will be at the Tier 4 Drug (Specialty Drugs) level.

Sexual Dysfunction Drugs

Drugs that establish, maintain, or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary and on the Essential Drug List. These Prescription Drugs are covered for up to the number of doses or tablets specified in Health Net's Essential Drug List For information about Health Net's Essential Drug List, please call the Customer Contact Center at the telephone number on your ID card or visit our website at www.myhealthnetca.com.

Specialty Drugs

Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and usually require close monitoring. These drugs may have limited pharmacy availability or distribution and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously, intramuscularly, or intravenously). Specialty Drugs are identified in the Health Net Essential Drug List with "SP." Refer to Health Net's Essential Drug List on our website at www.myhealthnetca.com for the Specialty Drugs listing. You can also call the Customer Contact Center telephone number listed on your Health Net ID card.

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

Self-injectable drugs (other than insulin), including drugs for the treatment of hemophilia, and needles and syringes used with these self-injectable drugs are included under Specialty Drugs, which are subject to Prior Authorization and must be obtained through Health Net's contracted specialty pharmacy vendor.

Preventive Drugs and Contraceptives:

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

Drugs for the relief of nicotine withdrawal symptoms require a prescription from the treating Physician. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.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 that are either available over-the-counter or are available with a Prescription Drug Order. Contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal, and emergency contraceptives and condoms. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Essential Drug List.

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

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

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

What Is the Health Net Essential Drug List?

Health Net developed the Essential 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 Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Essential Drug List identifies whether a generic version of a Brand Name Drug exists and whether Prior Authorization is required. If the generic version exists, it will be dispensed instead of the brand name version, 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 Drug List. You may also request a copy of the current List and it will be mailed to you. The current List is also available on the Health Net website at www.myhealthnetca.com. To obtain specific benefit and drug information, including your cost for a specific drug at your preferred pharmacy, please log into your secure Member portal or call the Customer Contact Center at the number on your Health Net ID card.

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

The Essential Drug List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on Essential 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 Drug List. The Essential Drug List is updated as new information and medications are approved by the FDA.

Who is on the Health Net Pharmacy and Therapeutic Committee and How Are Decisions Made?

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

Step Therapy

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

Step Therapy Exception

A step therapy exception is defined as a decision to override a generally applicable step therapy protocol in favor of coverage of the Prescription Drug prescribed by a health care provider for a Member. For more information on the step therapy exception process, please see “Step Therapy Exception” in the Essential Drug List on www.myhealthnetca.com.

Prior Authorization and Step Therapy Exception Process for Prescription Drugs

The Essential Drug List identifies which drugs require Prior Authorization or step therapy. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net. Step therapy exceptions are also subject to the Prior Authorization process. You may obtain a list of drugs requiring Prior Authorization by visiting our website at www.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 Drug List, your Physician should call Health Net to determine if the drug requires Prior Authorization. Health Net may approve a drug not on the Essential Drug List if Medical Necessity is demonstrated by the prescribing Physician as follows:

- Drugs on the Essential Drug List have already been tried and were not effective;

- The medication being considered meets Health Net's usage guidelines; and
- The medication is not excluded from the Member's Plan.

Your Physician should call Health Net to request Prior Authorization for drugs not on the Essential Drug List.

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

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

Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the 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 the Prior Authorization or step therapy exception request is approved, drugs will be covered, including refills, as shown in the "Schedule of Benefits" section. If the Prior Authorization or step therapy exception is denied, the drug is not covered, and you are responsible for the entire cost of the Drug.

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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

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 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. See also the "Schedule II Narcotic Drugs" portion of the "Exclusions and Limitations" section.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. If 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, Copayment or Coinsurance shown in the "Schedule of Benefits" section.

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

Pharmacy Lock-In Program

Health Net's pharmacy services, together with Medical Management, will review a Member's medication usage and history, and using specific criteria, will enroll Members in the Pharmacy Lock-In Program. The Lock-In Program criteria is included in the Essential Drug List, which is posted on the Health Net website at www.myhealthnetca.com.

Members enrolled in this program will be limited to using a specific retail pharmacy to obtain all Prescription Drugs, with the exception of Prescription Drugs dispensed in conjunction with Emergency Care, 90-day supply of Maintenance Drugs through the mail-order program and Specialty Drugs obtained through the specialty pharmacy vendor.

The program enrollment notice will be sent to the Member, prescribing Physician and designated pharmacy and will include information on the duration of enrollment, pharmacy to which the Member is locked-in, and Member grievance rights.

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 the "Definitions" section 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, less any applicable Deductible, Copayment or Coinsurance shown in the "Schedule of Benefits" section.

If you present a Prescription Drug Order for a Brand Name Drug, the pharmacist 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 the "Exclusions and Limitations" section and the requirements of the Essential Drug List described above still applies 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 mail order program.

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

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

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

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

Note: Tier 4 Drugs (Specialty Drugs) and Schedule II narcotic drugs are not covered through our mail order program. Refer to the "Prescription Drug" portion of the "Exclusions and Limitations" section for more information.

Pediatric Dental Services

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

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

Accessing Pediatric Dental Services

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.

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

Network Benefits

All pediatric dental services must be provided by a Health Net participating dental provider in order to be covered.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider.

We can provide assistance in referring you to a network dental provider. We will make available to you a *Directory of Network Dental Providers*. You can also call Customer Service to determine which providers participate in the Network. The telephone number for Customer Service is on your ID card.

Benefits for eligible dental expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge. In no event, will you be required to pay a network dental provider an amount for a covered dental service in excess of the contracted fee.

A network provider cannot charge you or us for any service or supply that is not Medically Necessary as determined by us. If you agree to receive a service or supply that is not Medically Necessary, the network provider may charge you. However, these charges will not be considered covered dental services and benefits will not be payable.

Covered Dental Services

Benefits are available only for Medically Necessary dental services. The fact that a dental provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a covered dental service under this *Plan Contract*.

Teledentistry Benefits

This dental plan covers Medically Necessary Teledentistry benefits as described in the "Pediatric Dental Services" portion of the "Schedule of Benefits." Teledentistry services must be provided by a Health Net participating dental provider from our network.

Pre-Treatment Estimate

If the charge for a dental service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your dental provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the dental provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a covered dental service and will estimate the amount of payment. The estimate of benefits payable will be sent to the dental provider and will be subject to all terms, conditions and provisions of the *Plan Contract*.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Benefits for Pediatric Dental Services

Benefits are provided for the dental services stated in this subsection when such services are:

A. Medically Necessary.

B. Provided by or under the direction of a network dental provider.

C. Not excluded as described in the "Pediatric Dental Services" portion of the "Exclusions and Limitations" section.

Pediatric Vision Services

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

The services and supplies described in this section are covered when provided by a Participating Vision Provider. The amount covered may vary based on the type of provider used and on the type of eyewear obtained.

The pediatric vision services benefits are provided by Health Net. Health Net contracts with Centene Vision Services, 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.

The following services and supplies are covered under this *Plan Contract*, subject to all provisions of this *Plan Contract*:

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" section. Vision examination includes dilation, if professionally indicated.

Frame: One frame for eyeglasses, up to the maximum number described in the "Schedule of Benefits" section.

Eyeglass Lenses: Eyeglass lenses subject to the benefit maximums described in the "Schedule of Benefits" section.

Cosmetic Contact Lenses: When contact lenses are chosen for nonmedical or cosmetic reasons, the lenses are payable only as a replacement of benefits for other eyewear.

Medically Necessary Contact Lenses: Contact lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, aniseikonia, corneal disorders, post-traumatic disorders, and irregular astigmatism. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Medically Necessary contact lenses are dispensed in lieu of other eyewear.

Subnormal or Low Vision Services and Aids: Health Net covers one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers, or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years).

Notice and Proof of Claim and Claim Forms: Claims for pediatric vision services should be submitted by the Participating Vision Provider, however, if the Member needs to submit a claim, written notice of a claim must be given to Health Net within 90 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Health Net of a vision claim at P.O. Box 8504, Mason, OH 45040-7111.

Upon enrollment Health Net will furnish the Member with Health Net's usual forms for filing proof of loss. If Health Net does not furnish the Member with the usual form, the Member can comply with the requirements for furnishing proof of loss by submitting written proof within the 90-day period stipulated above. Such written proof must cover the occurrence, the character, and the extent of the loss.

The Member must submit proof of loss for covered services provided by a Provider.

Written notice of claim or proof of loss must be submitted no later than one year after the occurrence.

Health Net's Vision Claim address is:
Health Net Vision/Claims
P.O. Box 8504
Mason, OH 45040-7111

Members are required to submit to Health Net in writing an itemized statement of the charges incurred by the Member, along with a completed claim form, to request reimbursement. Claim forms can be obtained by calling Customer Service Monday through Friday at **(866) 392-6058** from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Health Net will furnish the Member a claim form within 15 days of the Member's request. If Health Net does not furnish the claim form within 15 days, the Member shall be deemed to have complied with the requirements of this *Plan Contract* as to proof of loss upon submitting, within the time fixed in this *Plan Contract* for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made. Pharmacy claims do not require a completed claim form but must have an original receipt for the prescription with the patient's name and must be in English and in U.S. currency.

Proof of payment must accompany the request for reimbursement. Member requests for reimbursement must be forwarded to Health Net within 90 days of the date covered services were received. If it is not reasonably possible for a Member to submit proof of payment at the time the request for reimbursement is made, proof of payment must be submitted to Health Net as soon thereafter as is reasonably possible. Failure to provide proof of loss within the required time does not invalidate the claim if it was filed as soon as reasonably possible.

Payment of Claims

Benefits will be paid directly to the Member, unless otherwise directed by the Member, for covered services.

EXCLUSIONS AND LIMITATIONS

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

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the *Plan Contract and EOC*, exceed *Plan Contract and EOC* limitations or are Follow-Up Care (or related to Follow-Up Care) to *Plan Contract and EOC* exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to noncovered 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" in the "General Provisions" section) or is required to be covered by other state or federal law and is Medically Necessary as defined in the "Definitions" section.

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."

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

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Care, as defined in "Emergency Care" in the "Definitions" section, were not met, unless Prior Authorization was obtained, as discussed in the "Ambulance Services" provision of "Covered Services and Supplies;" or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the Plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

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

Please see the "Hospice Care" provisions in the "Covered Services and Supplies" and "Definitions" sections for services that are provided as part of that care, when authorized by Health Net.

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; or
- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Clinical Trials" provision in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section.

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

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

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 and EOC*, 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 31 days (including the date of birth) are excluded unless the baby is enrolled under this health Plan within 31 days (including the date of birth).

Personal or Comfort Items

This Plan does not cover personal or comfort items.

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 Health and Substance Use Disorder benefits:

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 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 the "Covered Services and Supplies" section for information about coverage of examinations that are for preventive health purposes.

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 physical disorders (such as incontinence and chronic Pain) and Mental Health and Substance Use Disorders.

Blood

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

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

Chiropractic Services

This Plan does not cover chiropractic services.

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, chemical face peels, abrasive procedures of the skin or epilation are not covered. Hairpieces, wigs, and cranial/hair prostheses are not covered, except as stated in the "Schedule of Benefits" section under "Medical Supplies."

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

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

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

Health Net determines the feasibility and extent of these services. These services are subject to the Prior Authorization requirements described in the "Prior Authorization Requirement" section of this *Plan Contract and EOC*. However, the length of Hospital stays related to mastectomies and lymph node

dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

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

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures will be subject to the Prior Authorization requirements described in the "Prior Authorization Requirement" section. However, Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Prior Authorization for determining the length of stay will not be 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 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 through Your PPO Plan" portion of the "Introduction to Health Net" section 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 the "Introduction to Health Net" section.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily noncovered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this *Plan Contract and EOC* and will only be covered under the following circumstances (a) Members who are under eight years of age, (b) Members who are developmentally disabled or (c) Members whose health is compromised, and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

The following services are not covered under any circumstances, except as 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 the "Covered Services and Supplies" section).

Dietary or nutritional supplements and specialized formulas may be covered as deemed Medically Necessary for Mental Health and Substance Use Disorder treatments when the dietary nutritional supplement or specialized formula is a component of a behavioral health treatment plan with a qualified provider for treatment of the Mental Health and Substance Use Disorder diagnosis. Coverage for the dietary or nutritional supplements and specialized formulas must be plan authorized, as required by Health Net.

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

See also "Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies" in the "Prescription Drugs" portion of this section.

Disorders of the Jaw

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

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

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

Durable Medical Equipment

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

- Appliances or devices for comfort or convenience; or luxury equipment or features.
- Alteration of your residence to accommodate your physical or medical condition, including the installation of elevators.

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

Excess Charges

Amounts charged by Out-of-Network Providers for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as described in the "Maximum Allowable Amount (MAA) for Out-of-Network Providers" section of this *Plan Contract and EOC*.

Fertility Preservation

Standard fertility preservation treatments are covered as shown in the "Fertility Preservation" provision in the "Covered Services and Supplies" section. 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. Biomarker testing is covered when determined by Health Net to be Medically Necessary, including for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. However, Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer. Genetic testing will not be covered for nonmedical reasons or when a Member has no

medical indication. For information regarding genetic testing and diagnostic procedures of a fetus, see the "Pregnancy" portion of the "Covered Services and Supplies" section.

Governmental Agencies

Any services provided by or for which payment is made by a local, state, or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid, or Medicare.

Hearing Aids

This Plan does not cover any analog or digital hearing aid devices which typically fit in or behind the outer ear and are used to improve hearing. The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0 to 20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.

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 and EOC*, have been met.

Immunizations and Injections

This Plan does not cover immunizations and injections for foreign travel or 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.

Inpatient Diagnostic Tests

Inpatient room and board charges incurred in connection with an admission to a Hospital or other inpatient treatment facility primarily for diagnostic tests at the Member's request which could have been performed safely on an outpatient basis or deemed not Medically Necessary for an inpatient setting.

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.

Noncovered Treatments

The following types of treatment are only covered when provided in connection with covered treatment for Mental Health and Substance Use Disorders:

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

Treatment of neurocognitive disorders which include delirium, major and mild neurocognitive disorders and their subtypes and neurodevelopmental disorders are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms or substance use disorder conditions only if amenable to psychotherapeutic, psychiatric, 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 Health and Substance Use Disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, as amended to date.

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

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 Hospital Confinements

Inpatient room and board charges in conjunction with a Hospital, Hospice or Skilled Nursing Facility stay primarily for environmental change, personal convenience or custodial in nature are not covered.

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

Nonlicensed Provider

Treatments or services rendered by health care providers who are required to be, but who are not, licensed by the state where they practice to provide the treatments or services. Treatment or services for which the provider of services is not required to be licensed are also excluded from coverage. This includes treatment or services from a nonlicensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by Health Net. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in this *Plan Contract and EOC* or certain Mental Health and Substance Use Disorder therapy and social work providers in training working under a licensed provider.

Nonstandard Therapies

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

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

Physician Self-Treatment

This Plan does not cover Physician self-treatment rendered in a nonemergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory tests, 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 Drugs" portion of the "Covered Services and Supplies" section.

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 Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical conditions and Mental Health and Substance Use Disorders, or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required Prior Authorization from Health Net. The services must be based on a treatment plan as authorized. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability

to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See the "General Provisions" section for the procedure to request independent medical review of a Plan denial of coverage on the basis of Medical Necessity.

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

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. The Copayment for Medically Necessary covered foot care with a Doctor of Podiatric Medicine (DPM) is the same as a visit to Physician, Physician Assistant or Nurse Practitioner.

Services for Educational or Training Purposes

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

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

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 or supplies for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Sports Activities

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

State Hospital Treatment

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

Surrogacy Arrangements

This Plan does not cover Health Care Services, including supplies and Prescription Drugs, to a Surrogate, including a Member and/or Family Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member and/or Family Member, and any child born as a result of a Surrogacy Arrangement. This exclusion applies to all Health Care Services, supplies and Prescription Drugs rendered to a Surrogate including, but not limited to:

- Prenatal care;
- Intrapartum care (or care provided during delivery and childbirth);
- Postpartum care (or care for the Surrogate following childbirth);
- Mental Health and Substance Use Disorders related to the Surrogacy Arrangement;
- Expenses relating to donor semen, including collection and preparation for implantation;
- Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
- Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
- Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;
- Any complications of the child or Surrogate resulting from the pregnancy; or
- Any other Health Care Services, supplies and Prescription Drugs relating to a Surrogacy Arrangement.

Any and all Health Care Services, supplies or Prescription Drugs provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are also excluded, except where the child is the adoptive child of the Member and/or the child is a Member at the time of birth.

Telehealth Consultations Through the Select Telehealth Services Provider

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

- Specialist services; and

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

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 (medical) or a mental health professional (Mental Health and Substance Use Disorders).

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 the "Covered Services and Supplies" section.

Treatment Related to Judicial or Administrative Proceedings

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

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

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 all 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 and EOC*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for more information.

Additional Exclusions and Limitations:

Allergy Serum

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

and the “Immunizations and Injections” portion of “Covered Services and Supplies” section for more information.

Appetite Suppressants or Drugs for Body Weight Reduction

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

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” portion 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 Drug List and are subject to Prior Authorization from Health Net.

Phenylketonuria (PKU) treatment is covered under the medical benefit (see the “Phenylketonuria” portion of the “Covered Services and Supplies” section).

Drugs Prescribed for the Common Cold

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

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

Drugs Prescribed for Cosmetic or Cognitive Performance Purposes

Drugs that are prescribed for the following nonmedical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and cognitive performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to Latisse, Renova, Retin-A, Vaniqa, Propecia, or Lustra. This exclusion does not exclude coverage for drugs when Prior 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 or Investigational Services" provision of this "Exclusions and Limitations" section.

Hypodermic Syringes and Needles

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

Infertility Services

This Plan does not cover Prescription Drugs prescribed for infertility.

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs

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

Nonapproved Uses

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

Noncovered Services

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

Non-Lock-In Pharmacy

For Members who are enrolled in the Pharmacy Lock-In Program, no benefits will be paid under the Prescription Drug benefit for services provided or expenses incurred for any Drug dispensed from a non-lock-in retail pharmacy even if the retail pharmacy is a Participating Pharmacy. However, this exclusion does not apply to Prescription Drugs dispensed in conjunction with Emergency Care, 90-day supply of

Maintenance Drugs through the mail-order program and Specialty Drugs obtained through the specialty pharmacy vendor.

Nonparticipating Pharmacies

Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "COVID-19 Outpatient Services" and the "Nonparticipating Pharmacies and Emergencies" provisions of the "Covered Services and Supplies" section.

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

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

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 narcotic drugs are not covered through mail order. 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.

Self-Injectable Drugs

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

Sexual Dysfunction Drugs

Drugs (including injectable medications) when on the Essential Drug List and Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30-day period.

Surrogacy Arrangement

Prescription Drugs prescribed to a Surrogate, including a Member and/or Family Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member and/or Family Member, and any child born as a result of a Surrogacy Arrangement.

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.

Pediatric Dental Services

The exclusions and limitations in the "Services and Supplies" portion of this section apply to Pediatric Dental Services. See the "Pediatric Dental Services" portion of the "Schedule of Benefits" 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 the "Covered Services and Supplies" section for more information.

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

Except as otherwise provided in the "Pediatric Dental Services" portion of "Covered Services and Supplies," all benefits must be provided by a Health Net participating dental provider in order to be covered. This dental Plan does not provide benefits for services and supplies provided by a dentist who is not the participating dental provider, except as specifically described under the "Pediatric Dental Services" portion of "Introduction to Health Net" section.

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, they may be eligible under the Early and Periodic Screening, Diagnosis and Treatment - Supplemental Services (EPSDT-SS) exception if Medical 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.

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

- Services which, in the opinion of the attending dentist, are not necessary to the Member’s dental health.

- 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 and Evidence of Coverage* for your health plan with Health Net for more information.
- 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.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member becomes eligible for such services.
- Dispensing of drugs not normally supplied in a dental office.
- 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 their panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or their plan provider is a pedodontist/pediatric dentist.
- Dental services that are received in an Emergency Care setting for conditions that are not emergencies if the Member reasonably should have known that an Emergency Care situation did not exist.

- Services from a nonnetwork provider.

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.

Pediatric Vision Services

The exclusions and limitations in the "Services and Supplies" portion 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 *Plan Contract and Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section, 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:

Nonparticipating 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 eyeglass lenses and frames. See the "Pediatric Vision Services" portions of "Schedule of Benefits" 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 (nonprescription) lenses, lenses are excluded unless specifically identified as a covered service in the "Pediatric Vision Services" portion of the "Schedule of Benefits" 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.

Acupuncture Services

The exclusions and limitations in the "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 the "Covered Services and Supplies" section for more information.

Services, laboratory tests, x-rays and other treatment not approved by ASH Plans and documented as Medically/clinically Necessary as appropriate or classified as Experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life-threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

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

Auxiliary Aids

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

Diagnostic Radiology

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

Drugs

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

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

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

Experimental or Investigational Acupuncture Services

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

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*.

Entire Agreement

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

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.

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*.

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 Ambetter Individual Products PO Box 980438, West Sacramento, CA 95798-0438.

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.

Nondiscrimination

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 disability.

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.

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

Members have the responsibility 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.

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 the number on the back of your Health Net ID card 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
Attention: Appeals and Grievance
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, 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 ID 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, the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review ("IMR") of disputed Health Care Services from the Department of Managed Health Care ("Department") if you believe that Health Care Services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or

delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any Health Care Service eligible for coverage and payment under your Health Net Plan that has been denied, modified, or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

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

Eligibility

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

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

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

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

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

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review ("IMR") of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

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

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

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-888-926-4988)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not

prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Binding Arbitration

As a condition to becoming a Health Net Member, **YOU AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF YOUR HEALTH NET MEMBERSHIP TO FINAL BINDING ARBITRATION 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 *Plan Contract and Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically, such disputes are handled and resolved through the Health Net grievance, appeal and independent medical review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, Health Net uses binding bilateral arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise and whether or not other parties such as employer groups, health care providers or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered) also must be submitted to binding arbitration.

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

neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

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

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

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered Investigational or Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational or Experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or Investigational or Experimental, following extensive review of medical research by appropriately specialized Physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or Investigational or Experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies, or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net's decision from the Department of

Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

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

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all covered 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 provider's effort to obtain reimbursement, including:

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

How the Amount of Your Reimbursement is Determined

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

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

- The amount of the reimbursement that you owe Health Net, or the medical provider will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the medical provider will also be reduced a pro rata share for any legal fees or costs that you paid from the money you received.

- The amount that you will be required to reimburse Health Net or the medical provider for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

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

Surrogacy Arrangements

Definitions of "Surrogate" and "Surrogacy Arrangement" can be found in the "Definitions" section.

Duty to Cooperate

Members who are a Surrogate at the time of enrollment or Members who agree to a Surrogacy Arrangement must, within 30 days of enrollment or within 30 days of entering into a Surrogacy Arrangement, send written notice of the Surrogacy Arrangement to the Plan at the following address:

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

In the event that a Member fails to comply with this provision, we reserve our right to enforce this *Plan Contract and EOC* on the basis of fraud, misrepresentation or false information, up to and including recoupment of all benefits that we paid on behalf of the Surrogate during the time that the Surrogate was covered under this *Plan Contract and EOC*, plus interest, attorneys' fees, costs and all other remedies available to us.

Relationship of Parties

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

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

All of the parties are independent contractors and contract with each other to provide you the covered 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 Participating Providers, any Physician or Hospital or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of this Plan.

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Contracting Administrators

Health Net may designate or replace any contracting administrator that provides the covered 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 and EOC*.

Decision-Making Authority

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

Continuity of Care Upon Termination of Provider Contract

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

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal Mental Health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or

- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

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

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

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

Cash Benefits

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

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

Benefits Not Transferable

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

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

Notice of Claim

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

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

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

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

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

Health Net
7625 North Palm Avenue
Suite 107
Fresno, CA 93711

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 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, 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, Member ID number, address, and telephone number on all requests for reimbursement.

Payment of Claim

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

Payment to Providers or Subscriber

Benefit payment for Covered Expenses will be made directly to:

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

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

Payment When Subscriber is Unable to Accept

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

Health Care Plan Fraud

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

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

Physical Examination

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

Foreign Travel or Work Assignment

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

Interpretation of Plan Contract and EOC

The laws of the state of California shall be applied to interpretations of this *Plan Contract and EOC*.

Disruption of Care

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

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered 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 through Your PPO Plan" section under "Introduction to Health Net."

Transfer of Medical Records

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

Confidentiality of Medical Records

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

Notice of Privacy Practices

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

Covered Entities Duties:

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

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

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

- The uses or disclosures
- Your rights
- Our legal duties
- 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

***This Notice of Privacy Practices applies to enrollees in any of the following Health Net entities:** Health Net of California, Inc., Health Net Community Solutions, Inc., and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. Rev. 03/02/2023.*

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

Permissible Uses and Disclosures of Your PHI:

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

- ***Treatment*** - We may use or disclose your PHI to a Physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the Health Care Services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - Processing claims
  - Determining eligibility or coverage for claims
  - Issuing premium billings
  - Reviewing services for Medical Necessity
  - 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 disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect, or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court
  - Administrative tribunal
  - Subpoena
  - Summons
  - Warrant
  - Discovery request
  - Similar legal request

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order
  - Court-ordered warrant
  - Subpoena
  - Summons issued by a judicial officer
  - 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 previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

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

Impermissible Use of PHI - We will not use your language, race, ethnic background, sexual orientation, and gender identity information to deny coverage, services, benefits, or for underwriting purposes.

Individuals Rights

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

The state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc., and Health Net Life Insurance Company (Health Net, Inc.) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose Medical Information related to Sensitive Services provided to a Protected Individual to the Subscriber or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care.
- ***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 telephone number on the back of your ID card**.

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Plan Contract and EOC* 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.

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.

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

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

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

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

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

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

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

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

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

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to,

disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

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

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

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

Deductible is a set amount you pay for specified Covered Expenses before Health Net pays any benefits for those Covered Expenses in that Calendar Year. Refer to the "Schedule of Benefits" section 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 their spouse (including legally adopted children, stepchildren, and children for whom the Subscriber is a court-appointed guardian).
- A parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Health Net Ambetter PPO Service Area.

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

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

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).

- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

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

Emergency 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 their 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 their license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, either within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute Hospital or to an acute psychiatric Hospital as Medically Necessary.

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

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

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

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 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 Drug List require Prior Authorization from Health Net in order to be covered.

Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, dental service, device or supply which Health Net has not determined to have been demonstrated as safe, effective, or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

With regard to Acupuncture Services, "Experimental" services are acupuncture care that is a currently unproven Acupuncture Service that does not meet professionally recognized, valid, evidence-based standards of practice.

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

Family Members are Dependents of the Subscriber, who meet the eligibility requirements for coverage under this 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 their license or as otherwise authorized under California law.

Health Net Essential 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 Drug List require Prior Authorization from Health Net in order to be covered.

Health Net of California, Inc. (herein referred to as **Health Net**) is a California licensed health care service plan.

Health Net Ambetter PPO is the Preferred Provider Organization (PPO) plan described in this *Plan Contract and EOC*, which allows you to obtain covered services and supplies from either a network of Preferred Providers or Out-of-Network Providers.

Health Net Ambetter PPO 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 individuals and provide benefits through approved health plans.

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

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

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

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

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

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

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.

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

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

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

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

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

Medically Necessary (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:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- 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.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

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

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

Member is the Subscriber or an enrolled Family Member.

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.

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-Network Providers are Physicians, Hospitals, laboratories, or other providers of health care licensed to and providing services in California who are not part of the Health Net Preferred Provider Organization (PPO), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which you or your family must pay for medical, outpatient Prescription Drug, pediatric dental and pediatric vision Covered Expenses during a Calendar Year. After that maximum is reached for services provided by a Preferred Provider, and out-of-network Emergency Care (including emergency Hospital care and emergency transportation), your payment responsibilities for Copayments and Coinsurance will no longer apply for Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits." Penalties paid for services which were not authorized as required will not be

applied to the Out-of-Pocket Maximum, and your responsibility for these penalties will continue to apply to these expenses after the Out-of-Pocket Maximum is reached. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum. Deductibles, Copayments and Coinsurance for out-of-network Emergency Care, including emergency Hospital care and emergency medical transportation, accrues to the in-network Out-of-Pocket Maximum.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition. Pain includes low back Pain, post-operative Pain, and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net to provide Mental Health and Substance Use Disorder benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or substance use disorder rehabilitation services. Services provided at a facility under the out-of-network level of benefit must meet these same licensing requirements.

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

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

Participating Providers (See “Preferred Providers” definition)

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

Dentist (D.D.S.)
Optometrist (O.D.)
Dispensing optician
Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
Psychologist
Acupuncturist (A.C.)
Nurse midwife
Nurse Practitioner
Physician Assistant
Clinical social worker (M.S.W. or L.C.S.W.)

Marriage, family and child counselor (M.F.C.C.)
Physical therapist (P.T. or R.P.T.)
Speech pathologist
Audiologist
Occupational therapist (O.T.R.)
Psychiatric mental health nurse
Respiratory care practitioner
Other Mental Health and Substance Use Disorder providers, including, but not limited to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

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

Plan is the health benefits purchased by you and described in this *Plan Contract and EOC*.

Plan Contract or Plan Contract and Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

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

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

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

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

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

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

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

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

Primary Care Physician is a Physician who maintains an ongoing relationship with you and who knows you well and whom you trust in as an important part of a good health care program. Primary Care Physicians include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists. Information on how to select a Primary Care Physician and a listing of the Primary Care Physician's in the Health Net Ambetter PPO 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 ID card to request provider information.

Prior Authorization refers to the requirement that certain Covered Expenses require review and approval, frequently prior to the expenses being incurred. The "Schedule of Benefits" shows the penalties applicable to those expenses which are authorized in accordance with the provisions of this *EOC*, and those expenses which are not so authorized. The requirements for Prior Authorization are described in the "Prior Authorization Requirement" section of this *Plan Contract and EOC*.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a noninstitutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Protected Individual means any adult covered by the Subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A health care service plan shall not require a Protected Individual to obtain the Subscriber, or other enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the Protected Individual has the right to consent to care.

Psychiatric Emergency Medical Condition means a Mental Health and Substance Use 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 themself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Health and Substance Use Disorder.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides

treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional:

  A. Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;

  B. Is supervised by a Qualified Autism Service Provider;

  C. Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; and

  D. Is either of the following:

    i. Is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; or

    ii. A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology;

  E. Is either of the following:

    i. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; or

    ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional; and

  F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical, and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

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

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

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

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 Physician who delivers specialized services and supplies to the Member.

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*.

Substance Use Disorder Care Facility is a Hospital, Residential Treatment Center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is state licensed to provide substance use disorder detoxification services or rehabilitation services.

Surrogacy Arrangement means an understanding in which a woman (the Surrogate) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the Surrogate receives payment for acting as a Surrogate.

Surrogate means an individual who, as part of a Surrogacy Arrangement, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Teledentistry can include patient care and education. See the definition of "Telehealth Services" below.

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 include most Generic Drugs and low-cost preferred Brand Name Drugs.

Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs, and any other drugs recommended by Health Net’s Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost.

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by Health Net’s Pharmacy and Therapeutics Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 Drugs (Specialty Drugs) are Prescription Drugs that consist of nonpreferred Brand Name Drugs or drugs listed in the Health Net Essential Drug List and include drugs: (a) 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 six hundred dollars ($600) net of rebates for a one month supply.

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

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

LANGUAGE ASSISTANCE SERVICES

Health Net provides free language assistance services, such as 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

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 bąąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shich[' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíį[' hodíilnih ninaaltsoos nanitingo bee néého'dolzinígíí 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 (Off Exchange (IFP به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

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

NONDISCRIMINATION NOTICE

In addition to the state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. 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, gender affirming care, 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./Health Net Life Insurance Company Appeals & Grievances
P.O. Box 10348
Van Nuys, CA 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.

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Contact us

For more information, please contact us at:

Health Net Ambetter Individual & Family Sales Enrollment Unit
Post Office Box 989731
West Sacramento, CA 95798-9731

Customer Contact Center

On Exchange: 1.888.926.4988

www.myhealthnetca.com