



PLAN CONTRACT AND EVIDENCE OF COVERAGE

A complete explanation of your Plan

Health Net of California, Inc. IEX

Plan Contract and Evidence of Coverage

Bronze 60 Ambetter HMO AI-AN

PLAN: NVM

EOCID: 580289

Important benefit information - please read

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE SERVICE AREA AND OBTAINING SERVICES FROM AMBETTER HMO NETWORK PHYSICIAN AND HOSPITAL PROVIDERS AND AMBETTER PHARMACY NETWORK PHARMACIES

Except for Emergency Services and Care, benefits for Physician and Hospital services under this **Health Net Ambetter HMO Network** (“Ambetter HMO Network”) Plan are only available when you live in the Service Area and use an Ambetter HMO Network Physician or Hospital. However, if you receive Covered Benefits at an Ambetter HMO Network health facility at which or as a result of which you receive services provided by a noncontracted provider, you will pay no more than the same cost-sharing you would pay for the same Covered Benefits received from an Ambetter HMO Network provider. When you enroll in this Ambetter HMO Network Plan, you may only use a Physician or Hospital that is in the Ambetter HMO Network, except as noted above, and you must choose an Ambetter HMO Network Primary Care Physician. You may obtain ancillary, pharmacy or behavioral health Covered Benefits from any Health Net participating ancillary, pharmacy or behavioral health provider.

Obtaining Covered Benefits under the Health Net Ambetter HMO Network Plan

Type of Provider	Available From
HOSPITAL	*Only Ambetter HMO Network Hospitals
PHYSICIAN	*Only Ambetter HMO Network Physicians
ANCILLARY	All Health Net Contracting Ancillary Providers
PHARMACY	Only Health Net Ambetter Pharmacy Network
BEHAVIORAL HEALTH.....	All Health Net Contracting Behavioral Health Providers

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

Note(s):

- Not all Physician and Hospitals that contract with Health Net are Ambetter HMO Network providers. Only those Physicians and Hospitals specifically identified as participating in the Ambetter HMO Network may provide services under this Plan, except as described in the chart above.

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

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

- Health Net
- Service Area
- Hospital
- Member Physician, Participating Physician Group, Primary Care Physician, Physician, participating provider, contracting Physician Groups and contracting providers
- Network
- Provider directory

Health Net Ambetter Pharmacy Network

- Not all pharmacies that contract with Health Net are in the Health Net Ambetter Pharmacy Network. Except in an emergency, 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 Nonparticipating Pharmacies under this Plan.
- Unless specifically stated otherwise, use of the following terms in this *Plan Contract and Evidence of Coverage* solely refers to the Ambetter Pharmacy Network as explained above.
 - o Participating Pharmacy
 - o Health Net contracting retail pharmacy
 - o Contracted pharmacy

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

Health Net Ambetter HMO Network Alternative Access Standards

The Ambetter HMO Network includes participating primary care and Specialist Physicians, and Hospitals in the Service Area. However, Members residing in the following zip codes will need to travel as indicated to access a participating PCP and/or receive nonemergency Hospital services.

16– 30 Miles

Imperial County: 92227 – Brawley (PCP); 92233 – Calipatria (PCP); 92250 – Holtville (PCP)

Kern County: 93203 – Arvin (PCP); 93225 – Frazier Park (PCP); 93238 – Kernville (PCP); 93263 – Shafter (PCP); 93276 – Tushman (PCP); 93280 – Wasco (PCP); 93311 – Bakersfield (PCP); 93501 – Mojave (PCP); 93505 – California City (Hospital); 93531 – Keene (PCP); 93561 – Tehachapi (PCP); 93596 – Boron (PCP)

Los Angeles County: 90263 – Malibu (Hospital: 24 miles); 90264 – Malibu (Hospital: 25 miles); 90265 – Malibu (PCP); 91023 – Mount Wilson (PCP); 91042 – Tujunga (Hospital: 23 miles); 91301 – Agoura Hills (Hospital: 26 miles); 91350 – Santa Clarita (Hospital: 21 miles); 91362 – Thousand Oaks

(Hospital: 22 miles); **91384** – Castaic (PCP); **91390** – Santa Clarita (PCP); **91702** – Azusa (PCP); **91759** – Mt. Baldy (PCP); **93510** – Acton (PCP); **93532** – Lake Hughes (PCP); **93543** – Littlerock (Hospital: 27 miles); **93544** – Llano (PCP); **93553** – Pearlblossom (Hospital: 29 miles); **93563** – Valyermo (PCP); **93591** – Palmdale (PCP)

Orange County: **92674** – San Clemente (Hospital: 21 miles); **92675** – San Clemente (Hospital: 29 miles); **92676** – Silverado (PCP: 21 miles and Hospital: 24 miles)

Riverside County: **92220** – Banning (Hospital: 23 miles); **92241** – Desert Hot Springs (Hospital: 25 miles); **92254** – Mecca (PCP); **92530** – Lake Elsinore (PCP); **92532** – Lake Elsinore (Hospital: 23 miles); **92536** – Aguanga (PCP); **92544** – Hemet (PCP); **92549** – Idyllwild (Hospital: 28 miles); **92561** – Mountain Center (PCP); **92590** – Temecula (Hospital: 21 miles); **92592** – Temecula (PCP) **92882** – Corona (Hospital: 26 miles); **92883** – Corona (Hospital: 26 miles)

San Bernardino County: **92252** – Joshua Tree (PCP); **92277** – Twentynine Palms (PCP); **92284** – Yucca Valley (PCP); **92307** – Apple Valley (PCP); **92308** – Apple Valley (Hospital 24 miles); **92339** – Baker (Hospital 26 miles); **92342** – Helendale (PCP); **92345** – Hesperia (Hospital 24 miles); **92368** – Oro Grande (Hospital 22 miles); **92371** – Phelan (Hospital 29 miles) **92372** – Pinon Hills (Hospital 30 miles); **92407** – San Bernadino (Hospital 22 miles)

San Diego County: **91917** – Dulzura (PCP); **91935** – Jamul (PCP); **91948** – Mount Laguna (PCP); **91962** – Pine Valley (PCP); **91963** – Potrero (PCP); **92004** – Borrego Springs (PCP); **92019** – El Cajon (Hospital 21 miles); **92027** – Escondido (Hospital 24 miles); **92028** – Fallbrook (Hospital 25 miles); **92040** – Lakeside (Hospital 26 miles); **92055** – Camp Pendleton (PCP); **92060** – Palomar Mountain (PCP); **92061** – Pauma Valley (PCP); **92066** – Ranchita (PCP); **92070** – Santa Ysabel (PCP)

Beyond 30 Miles

Imperial County: **92004** – Borrego Springs (PCP: 31 miles and Hospital: 42 miles); **92222** – Bard (Hospital: 65 miles); **92225** – Blythe (PCP: 71 miles and Hospital: 73 miles); **92257** – Niland (PCP: 39 miles and Hospital: 45 miles); **92259** – Ocotillo (Hospital: 40 miles); **92266** – Palo Verde (PCP: 60 miles and Hospital: 70 miles); **92274** – Thermal (PCP: 31 miles and Hospital: 45 miles); **92275** – Salton City (PCP: 36 miles and Hospital: 45 miles); **92283** – Winterhaven (PCP: 33 miles and Hospital: 70 miles)

Kern County: **93222** – Pine Mountain Club (PCP: 51 miles); **93224** – Fellows (Hospital 44 miles); **93225** – Frazier Park (PCP: 53 miles); **93226** – Glennville (PCP: 46 miles); **93243** – Lebec (PCP: 39 miles); **93249** – Lost Hills (PCP 33 miles and Hospital 56 miles); **93251** – McKittrick (PCP: 31 miles and Hospital 54 miles); **93252** – Maricopa (PCP: 39 miles and Hospital 71 miles); **93255** – Onyx (PCP: 31 miles); **93268** – Taft (PCP 33 miles); **93276** – Tupman (Hospital 36 miles); **93280** – Wasco (Hospital 37 miles); **93283** – Weldon (PCP: 36 miles); **93285** – Wofford Height (PCP: 32 miles); **93287** – Woody (PCP: 39 miles); **93306** – Buttonwillow (PCP: 40 miles); **93307** – Bakersfield (PCP: 35 miles); **93308** – Bakersfield (PCP: 39 miles); **93311** – Bakersfield (PCP: 38 miles); **93313** – Bakersfield (Hospital 32 miles); **93501** – Mojave (44 miles); **93505** – California City (PCP: 38 miles and Hospital 35 miles); **93516** – Boron (PCP: 33 miles and Hospital 55 miles); **93518** – Caliente (PCP: 47 miles); **93523** – Edwards Air Force Base (PCP: 35 miles); **93524** – Edwards Air Force Base (PCP: 36 miles); **93560** – Rosamond (PCP: 38 miles); **93561** – Tehachapi (32 miles); **93596** – Boron (49 miles)

Los Angeles County: **90704** – Avalon (PCP: 31 miles); **91384** – Castaic (Hospital: 35 miles); **93243** – Lebec (PCP: 35 miles); **93532** – Lake Hughes (PCP: 41 miles); **93535** – Lancaster (PCP: 34 miles);

93536 – Lancaster (PCP: 36 miles); **93544** – Llano (Hospital: 37 miles); **93560** – Rosamond (PCP: 37 miles); **93563** – Valyermo (Hospital: 38 miles); **93591** – Palmdale (Hospital: 35 miles)

Riverside County: **92254** – Mecca (PCP: 31 miles and Hospital: 36 miles); **92274** – Thermal (Hospital: 46 miles); **92536** – Aguanga (Hospital: 35 miles); **92539** – Anza (Hospital: 48 miles); **92544** – Hemet (Hospital: 32 miles); **92561** – Mountain Center (Hospital: 38 miles)

San Bernardino County: **92268** – Pioneertown (Hospital 33 miles); **92277** – Twentynine Palms (Hospital 43 miles); **92285** – Landers (PCP: 36 miles); **92305** – Angelus Oaks (PCP: 31 miles); **92307** – Apple Valley (Hospital 26 miles); **92309** – Baker (PCP: 69 miles); **92310** – Fort Irwin (PCP: 41 miles); **92311** – Barstow (PCP: 40 miles); **92347** – Hinkley (PCP: 48 miles); **92356** – Lucerne Valley (PCP: 45 miles and Hospital 43 miles); **92365** – Newberry Springs (PCP: 47 miles); **92397** – Wrightwood (Hospital 32 miles); **93516** – Boron (PCP: 32 miles)

San Diego County: **91901** – Alpine (Hospital 36 miles); **91905** – Boulevard (Hospital 63 miles); **91906** – Campo (Hospital 56 miles); **91916** – Descanso (Hospital 34 miles); **91917** – Dulzura (Hospital 36 miles); **91931** – Guatay (Hospital 38 miles); **91934** – Jacumba (Hospital 55 miles); **91935** – Jamul (Hospital 31 miles); **91948** – Mount Laguna (Hospital 48 miles); **91962** – Pine Valley (Hospital 56 miles); **91963** – Potrero (Hospital 42 miles); **91980** – Tecate (Hospital 42 miles); **92004** – Borrego Springs (Hospital 66 miles); **92036** – Julian (PCP: 49 miles); **92060** – Palomar Mountain (Hospital 34 miles); **92061** – Pauma Valley (Hospital 45 miles); **92065** – Ramona (Hospital 35 miles); **92066** – Ranchita (Hospital 64 miles); **92070** – Santa Ysabel (Hospital 49 miles); **92086** – Warner Springs (PCP: 41 miles and Hospital 57 miles)



Plan Contract and Evidence of Coverage (“Plan Contract”)

ISSUED BY

Health Net of California, Inc.

LOS ANGELES, CALIFORNIA

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

Plan Code: NVM

Health Net

A handwritten signature in cursive script, reading "Amy W. Krause".

Amy W. Krause
Secretary

A handwritten signature in cursive script, reading "Eric Schmacker".

Eric Schmacker
President

Use of Special Words

Special words used in this *Plan Contract* to explain your Plan have their first letter capitalized and appear in the “Definitions” section.

The following words are used frequently:

- “**You**” or “**Your**” refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been 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.
- “**Physician Group**” or “**Participating Physician Group (PPG)**” means the Health Net contracting medical group the individual Member selected as the source of all covered medical care.
- “**Primary Care Physician**” is the individual physician each Member selected who will provide or authorize all covered medical care.
- “**Plan**” and “***Plan Contract and Evidence of Coverage (EOC)***” have similar meanings. You may think of these as meaning your Health Net benefits.

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About This Booklet

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

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

Method of Provider Reimbursement

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

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” subsection 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 canceled. Health Net will mail a termination notice that will provide the following information: (a) that the *Plan Contract* has been canceled 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 canceled *Plan Contract* within the required 15 days or if the *Plan Contract* has previously been canceled 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(s):

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 a 60-day 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 canceled 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 months 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. Coverage is limited to Essential Health Benefits and other benefits as required under applicable federal or state laws. Services that are not Essential Health Benefits and are not otherwise required to be covered under applicable federal or state laws, are not covered under this *Plan Contract*.

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.

How to Obtain Care

When you enroll in this Plan, you must select a Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. Information on how to select a Primary Care Physician and a listing of the participating Primary Care Physicians in the 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.

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

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

1-888-926-4988 to ensure that you can obtain the Health Care Services that you need.

Transition of Care for New Enrollees

You may request continued care from a provider, including a Hospital, that does not contract with Health Net if your prior coverage was an individual plan that was terminated due to the health plan or health insurer no longer offering your health plan and, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

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

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

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

To request continued care for medical services, 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.

If you need continued care for Mental Health or Substance Use Disorders, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Selecting a Primary Care Physician

Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who

participates in our network and who is available to accept you or your Family Members, subject to the requirements set out below under “Selecting a Contracting Physician Group.”

For children, a pediatrician may be designated as the Primary Care Physician. Until you make your Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician and a listing of the participating Primary Care Physicians in the 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.

Selecting a Contracting Physician Group

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

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

Selecting a Participating Mental Health Professional

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

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

Specialists and Referral Care

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

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

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

Standing Referral to Specialty Care for Medical and Surgical Services

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

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

Changing Physician Groups

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

Your Financial Responsibility

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

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

Deductibles

For certain services and supplies under this Plan, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the 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 and Copayments" section for specific information on Deductibles.

Questions

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

Timely Access to Care

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

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

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

Definitions Related to Timely Access to Care

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

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

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

Scheduling Appointments with Your Primary Care Physician

When you need to see your Primary Care Physician (PCP), call their office for an appointment at the 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 them when you would like to see your doctor. They will make every effort to schedule an appointment at a time convenient for you. If you need to cancel an appointment, notify your Physician as soon as possible.

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

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Urgent care appointment with non-physician behavioral 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.
- **Life-Threatening behavioral health emergencies:** require immediate intervention and treatment.

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

Scheduling Appointments with a Specialist for Medical and Surgical Services

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

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

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

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

Scheduling Appointments for Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

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

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

Emergency and Urgently Needed Care

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

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

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

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

Except in an emergency or other urgent circumstances:

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

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

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

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

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

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

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

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

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

Definitions Related to Emergency Services and Care and Urgently Needed Care

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

Prescription Drugs

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

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

Note:

- The Prescription Drugs portion of the “Exclusions and Limitations” section and the requirements of the Ambetter from Health Net 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 pediatric dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe Pain, or acute infection that a person could reasonably expect that immediate dental care is needed.

All selected general dentists provide emergency pediatric dental services twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your selected general dentist. **If you require emergency pediatric 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 pediatric dental services, if any, is limited to the extent the treatment you received directly relates to emergency pediatric 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.

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SCHEDULE OF BENEFITS AND COPAYMENTS

The following schedule shows the Deductibles and Copayments (fixed dollar and percentage amounts) that you must pay for this Plan’s Covered Services and supplies.

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

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

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

For certain services and supplies under this Plan, as set out in this schedule, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed this Deductible.

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

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

Deductible for Certain Services

In any Calendar Year, you must pay charges for medical services subject to the Deductible until you meet one of the following Deductible amounts:

Calendar Year Deductible, per Member	\$5,800
Calendar Year Deductible, per family	\$11,600

Note(s):

The Calendar Year Deductible is required for certain medical services, as specifically noted below, 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 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.

Your payments under Prescription Drug, Pediatric Vision and Pediatric Dental are not applied to the medical Deductible.

The Calendar Year Deductible applies to all medical services, as specifically noted below. The Calendar Year Deductible does not apply to Preventive Care Services.

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 and Copayments you pay for Covered Services and supplies under this Plan Contract in any one Calendar Year equals the Out-of-Pocket Maximum amount, no payment for Covered Services and supplies may be imposed on any Member, except as described in “Exceptions to OOPM” below.

The OOPM amounts for this Plan are:

One Member	\$11,650
Family	\$23,300

Exception(s) to OOPM

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

How the OOPM Works

Here’s how the OOPM works:

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

You will be notified by us 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.

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.

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.

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

	Copayment
Use of emergency room facility.....	40% Coinsurance after deductible
Emergency room professional services	No charge
Use of urgent care center (facility and professional services)	\$60 Copay per visit

Copayment Exception(s):

- If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- For Emergency Services and Care in an emergency room or urgent care center, you are required to pay only the Deductible and Copayment amounts required under this Plan as described above. Refer to “Ambulance Services” below for emergency medical transportation Copayment.

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

	Copayment
Use of emergency room facility.....	40% Coinsurance after deductible
Emergency room professional services	No charge
Use of urgent care center (facility and professional services)	\$60 Copay per visit

Copayment Exception(s):

- If you are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- For Emergency Services and Care in an emergency room or urgent care center, you are required to pay only the Deductible and Copayment amounts required under this Plan as described above. Refer to “Ambulance Services” below for emergency medical transportation Copayment.

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

Copayment

Ground ambulance	40% Coinsurance after deductible
Air ambulance	40% Coinsurance after deductible

Note(s):

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

Ambulance Services (Mental Health or Substance Use Disorders)

Copayment

Ground ambulance	40% Coinsurance after deductible
Air ambulance	40% Coinsurance after deductible

Note(s):

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

Office Visits

Copayment

Visit to Physician, Physician Assistant, Nurse Practitioner, or Podiatrist	\$60 Copay per visit
Specialist consultation	\$100 Copay per visit after deductible.
Deductible is waived for the first 3 non-preventive visits*	
Hearing examination for diagnosis or treatment	\$60 Copay per visit
Vision examination for diagnosis or treatment (ages 19 and older) by an Optometrist**	\$60 Copay per visit
Vision examination for diagnosis or treatment (ages 19 and older) by an Ophthalmologist**	\$100 Copay per visit after deductible.
Deductible is waived for the first 3 non-preventive visits*	
Physician visit to a Member’s home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	\$60 Copay per visit
Specialist visit to a Member’s home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	\$100 Copay per visit after deductible.
Deductible is waived for the first 3 non-preventive visits*	
Annual Physical Examination***	Not covered
Telehealth consultation through the Select Telehealth Services Provider****	No charge

Note(s):

Self-referrals are allowed for obstetrician and gynecological services, and reproductive and sexual Health Care Services. (Refer to the “Obstetrician and Gynecologist (OB/GYN) Self-Referral” and “Self-Referral for Reproductive and Sexual Health Care Services” portions of the “Covered Services and Supplies” section.)

- * The Calendar Year Deductible applies after the first 3 nonpreventive Specialist visits.
- ** See “Pediatric Vision Services” for details regarding pediatric vision care services for ages younger than 19.
- *** 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.
- **** The designated Select Telehealth Services Provider for this Plan is listed on your Health Net ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Preventive Care Services

	Copayment
Preventive Care Services*	No charge

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 for those services.

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

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility.....	40% Coinsurance after deductible

Note(s):

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

Allergy, Immunizations and Injections

	Copayment
Allergy testing.....	\$100 Copay per visit after deductible. Deductible is waived for the first 3 non-preventive visits*
Allergy serum.....	40% Coinsurance after deductible
Allergy injection services	\$60 Copay per visit
Immunizations for occupational purposes or foreign travel	Not covered
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Injections (excluding injections for infertility)

Office based injectable medications (per dose) 40% Coinsurance after deductible

Note(s):

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

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

* The Calendar Year Deductible applies after the first 3 nonpreventive Specialist visits.

Rehabilitation and Habilitation Therapy**Copayment**

Physical therapy	\$60 Copay per visit
Occupational therapy	\$60 Copay per visit
Speech therapy	\$60 Copay per visit
Pulmonary therapy	\$60 Copay per visit
Cardiac therapy	\$60 Copay per visit
Habilitative therapy	\$60 Copay per visit

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” of the “Exclusions and Limitations” section.

Care for Conditions of Pregnancy**Copayment**

Prenatal care and preconception visits**	No charge*
Postnatal office visit**	\$60 Copay per visit
Newborn care office visit (birth through 30 days)**	\$60 Copay per visit
Physician visit to the mother or newborn at a Hospital	40% Coinsurance after deductible
Normal delivery, including cesarean section	40% Coinsurance after deductible
Circumcision of newborn (birth through 30 days)***	
In an inpatient setting	40% Coinsurance after deductible
In a Physician’s office or outpatient facility	40% Coinsurance after deductible

Note(s):

The above Copayments apply to professional services only. Services that are rendered in a Hospital or in an outpatient surgery setting are also subject to the applicable inpatient and outpatient

professional and facility Copayments. Look under the “Hospital Visits by Physician,” “Other Professional Services,” “Inpatient Hospital Services” and “Outpatient Facility Services” headings to determine any additional Copayments that may apply. Genetic testing is covered as a laboratory service as shown under the “Other Professional Services” heading below. Genetic testing through the California Prenatal Screening (PNS) Program at PNS-contracted labs, and follow-up services provided through PNS-contracted labs and other PNS-contracted providers are covered in full.

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

- * The Calendar Year Deductible does not apply.
- ** Termination of pregnancy and related services are covered in full. Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full. See “Preventive Care Services” above. If other non-Preventive Care Services are received during the same office visit, the above Copayment will apply for the non-Preventive Care Services. Refer to “Preventive Care Services” and “Pregnancy” under the “Covered Services and Supplies” section.
- *** Circumcisions for Members age 31 days and older are covered when Medically Necessary under outpatient surgery. Refer to “Other Professional Services” and “Outpatient Facility Services” for applicable Copayments.

Family Planning

Copayment

Sterilization of female.....	No charge
Sterilization of male.....	No charge

Note(s):

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

Other Professional Services

Copayment

Surgery	
In an inpatient setting.....	40% Coinsurance after deductible
In a Physician’s office or outpatient facility	40% Coinsurance after deductible
Assistance at surgery	
In an inpatient setting.....	40% Coinsurance after deductible
In a Physician’s office or outpatient facility	40% Coinsurance after deductible
Administration of anesthetics	
In an inpatient setting.....	40% Coinsurance after deductible
In a Physician’s office or outpatient facility	40% Coinsurance after deductible
Chemotherapy	40% Coinsurance after deductible
Radiation therapy	40% Coinsurance after deductible
Laboratory services	\$50 Copay per visit
Diagnostic imaging (including x-ray) services	40% Coinsurance after deductible
CT, SPECT, MRI, MUGA and PET	40% Coinsurance after deductible
Medical social services	\$60 Copay per visit

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Patient education*	No charge
Nuclear medicine (use of radioactive materials)	40% Coinsurance after deductible
Renal dialysis	40% Coinsurance after deductible
Organ, tissue, or stem cell transplant**	See note below
Infusion therapy in a home, outpatient or office setting	40% Coinsurance after deductible

Note(s):

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

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

- * Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care and have no cost-sharing; however, if other medical services are provided at the same time that are not solely for the purpose of covered preventive care, the appropriate related Copayment will apply.
- ** Applicable Deductible or Copayment requirements apply to any services and supplies required for organ, tissue, or stem cell transplants. For example, if the transplant requires an office visit, then the office visit Copayment will apply. Refer to the “Organ, Tissue and Stem Cell Transplants” portion of the “Covered Services and Supplies” section for details.

Medical Supplies**Copayment**

Durable Medical Equipment, nebulizers, including	
face masks and tubing	40% Coinsurance after deductible
Orthotics (such as bracing, supports and casts)	40% Coinsurance after deductible
Diabetic equipment*	40% Coinsurance after deductible
Diabetic footwear	40% Coinsurance after deductible
Prostheses (internal or external)**	40% Coinsurance after deductible
Wigs (cranial prostheses)***	40% Coinsurance after deductible
Blood or blood products, except for drugs used to treat hemophilia,	
including blood factors****	40% Coinsurance after deductible

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.

- * Corrective Footwear for the management and treatment of diabetes are covered under the “Diabetic Equipment” benefit as Medically Necessary. For a complete list of covered diabetic equipment and supplies, please see “Diabetic Equipment” in the “Covered Services and Supplies” section.
- ** Prostheses includes coverage for Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank. Prostheses also includes coverage of ostomy and urological supplies. See the “Ostomy and Urological Supplies” portion of the “Covered Services and Supplies” section.

*** 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.

**** Drugs for the treatment of hemophilia, including blood factors, are considered self-injectable drugs and covered as a Tier 4 Drug (Specialty Drug) under the Prescription Drug benefit.

Home Health Care Services

Copayment

Home Health Care Services 40% Coinsurance after deductible

Limitation(s):

Limited to 100 Visits Per Year.

Hospice Services

Copayment

Hospice Care No charge

Inpatient Hospital Services

Copayment

Room and board in a semi-private room or Special Care Unit including ancillary (additional) services 40% Coinsurance after deductible

Note(s):

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

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

Outpatient Facility Services

Copayment

Outpatient surgery facility (surgery performed in a Hospital outpatient setting or Outpatient Surgical Center) 40% Coinsurance after deductible
Outpatient facility services (other than surgery) 40% Coinsurance after deductible

Note(s):

The above Copayments apply to facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services Copayments. Look under the “Care for Conditions

of Pregnancy” and “Other Professional Services” headings to determine any additional Copayments that may apply.

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

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

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

Skilled Nursing Facility Services

Copayment

Room and board in a semi-private room with ancillary (additional) services..... 40% Coinsurance after deductible

Note(s):

Limited to 100 days per year.

Mental Health or Substance Use Disorder Benefits

Copayment

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring) \$60 Copay per visit

Outpatient group therapy session..... \$30 Copay per visit

Outpatient services other than an office visit/professional consultation (including psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization, therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day, and other outpatient services including, but not limited to, laboratory services or rehabilitation when provided for a Mental Health or Substance Use Disorder condition)* 40% Coinsurance. \$60 max

Participating Mental Health Professional visit to a Member’s home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) \$60 Copay per visit

Participating Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center** 40% Coinsurance after deductible

Inpatient services at a Hospital, Behavioral Health Facility or Residential Treatment Center 40% Coinsurance after deductible

Detoxification at a Hospital, Behavioral Health Facility or Residential Treatment Center 40% Coinsurance after deductible

Note(s):

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

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

- * Medically Necessary services for Mental Health or Substance Use Disorders are not subject to the visit limitations shown elsewhere in this “Schedule of Benefits and Copayments” section.
- ** Inpatient visits by Participating Mental Health Professionals other than Physicians are included in the inpatient services facility fee.

Exception(s):

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

Acupuncture Services

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

Office Visits

	Copayment
New patient examination	\$60 Copay per visit
Each subsequent visit.....	\$60 Copay per visit
Re-examination visit	\$60 Copay per visit
Second opinion.....	\$60 Copay per visit

Note(s):

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

Limitation(s):

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.

Prescription Drugs

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

	Deductible and Copayment
Prescription Drug Deductible (per Member, per Calendar Year).....	\$450
Prescription Drug Deductible (per family, per Calendar Year).....	\$900

Retail Pharmacy (up to a 30-day supply)

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

Name Drugs \$20 Copay per prescription

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Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost		40% Coinsurance after prescription drug deductible. \$500 max applies after deductible is met
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier		40% Coinsurance after prescription drug deductible. \$500 max applies after deductible is met
Preventive drugs and contraceptives.....		No charge

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

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		40% Coinsurance after prescription drug deductible. \$500 max applies after deductible is met
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Maintenance Drugs through the Mail Order Program (up to a 90-day supply)

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Name Drugs		\$40 Copay per prescription
Tier 2 Drugs include nonpreferred Generic Drugs, preferred Brand Name Drugs and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost		40% Coinsurance after prescription drug deductible. \$1000 max applies after deductible is met
Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.....		40% Coinsurance after prescription drug deductible. \$1000 max applies after deductible is met
Preventive drugs and contraceptives.....		No charge

Note(s):

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

Prior authorization may be required. Insulin medications are covered up to a 30-day supply with a cost share maximum of \$35, or the applicable Copayment per prescription as shown above under "Retail Pharmacy," whichever is less. In addition, insulin medications are covered up to a 90-day

supply with a cost share maximum of \$105, or the applicable Copayment per prescription as shown above under “Maintenance Drugs through the Mail Order Program,” whichever is less.

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.

For information about the Ambetter from Health Net Drug List, please call the Customer Contact Center at the telephone number on your ID card.

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

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the “Prescription Drugs” portion of the “Covered Services and Supplies” and the “Exclusions and Limitations” sections.

Percentage Copayments will be based on Health Net’s contracted pharmacy rate.

Regardless of Prescription Drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs, including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net. Covered Brand Name Drugs are subject to the applicable Prescription Drug Deductible as required for Brand Name Drugs and the applicable Copayment for Tier 2, Tier 3 or Tier 4 (Specialty Drugs) Prescription Drugs.

Covered Prescription Drugs are subject to the applicable Prescription Drug Deductible as required.

Deductible:

If you are a Member in a family of two or more Members, you reach the Prescription Drug Deductible either when you meet the amount for any one Member, or when your entire family reaches the family amount.

Once you have met your Prescription Drug Deductible, you are only responsible for the applicable retail pharmacy or mail order Copayment, as described above (see below for Mail Order) each time a covered Prescription Drug is dispensed to you.

The amount applied toward your Prescription Drug Deductible for covered Prescription Drugs is Health Net’s contracted pharmacy rate or the pharmacy’s cost of the prescription, whichever is less.

The Prescription Drug Deductible does not apply to peak flow meters and inhaler spacers for the treatment of asthma, preventive drugs, contraceptives or diabetic supplies and equipment dispensed through a Participating Pharmacy.

Prior Authorization:

Prior Authorization may be required. Refer to the “Prescription Drugs” portion of the “Covered Services and Supplies” section for a description of Prior Authorization requirements or visit our website at www.ambetterhealth.com/en/ca 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. Covered preventive drugs include over-the-counter drugs and Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Forces A and B recommendations, including smoking cessation drugs. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order. Please see the "Preventive Drugs and Contraceptives" provision in the "Prescription Drugs" portion of the "Covered Services and Supplies" section for additional details.

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

Mail Order:

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

Diabetic Supplies:

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

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

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

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

Professional Services

	Copayment
Routine eye examination with dilation	No charge*
Examination for contact lenses	
Standard contact lens fit and follow-up	\$0*
Premium contact lens fit and follow-up	\$0*

Limitation(s):

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

Note(s):

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

Materials (includes frames and lenses)

	Copayment
Provider selected frames (one every 12 months)	No charge
Standard eyeglass lenses (one pair every 12 months)	\$0
• Single vision, bifocal, trifocal, lenticular	
• Glass or plastic, including polycarbonate	
Optional lenses and treatments including:	\$0
• UV treatment	
• Tint (fashion & gradient & glass-grey)	
• Standard plastic scratch coating	
• Photochromic/transitions plastic	

- Standard and premium anti-reflective coating
- Polarized
- Standard and premium progressive lens
- Hi-Index lenses
- Blended segment lenses
- Intermediate vision lenses

Provider selected contact lenses are covered, based upon the type of contact lenses selected, 1 every Calendar Year (In lieu of eyeglass lenses) No charge

- Standard (hard) contacts 1 contact per eye per every 12 months
- Monthly contacts (six-month supply)
- Bi-weekly (six-month supply)
- Dailies (three-month supply)
- Medically Necessary

Subnormal or low vision services and aids – supplemental testing, Follow-Up Care, and low vision aids No charge

Medically Necessary Contact Lenses:

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

Coverage of Medically Necessary contact lenses is subject to Medical Necessity. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses, lenses and frames. See “Pediatric Vision Services” portion of the “Exclusions and Limitations” for details of limitations.

Pediatric Dental Services

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

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

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

IMPORTANT: If you opt to receive dental services that are not Covered Services under this Plan, a participating dental provider may charge you 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 the Customer Contact Center at the telephone number on your Health Net dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review this *Plan Contract and Evidence of Coverage document*.

If there are no network dental providers available within the access standards for a given zip code, the Member can ask to see an out-of-network dental provider at the in-network cost share by calling Customer Service at **(866) 249-2382**. If we determine that an in-network dental provider is not within the access standards for your zip code, the Plan will verbally approve the request during the Customer Service call and the Member will only be responsible for the in-network dental cost share.

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

Code	Service	Member Copayment
Diagnostic		
D0120	Periodic oral evaluation - established patient limited to 1 every 6 months	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge

Code	Service	Member Copayment
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit) up to six times in a 3-month period and up to a maximum of 12 in a 12-month period	No Charge
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation - new or established patient	No Charge
D0210	X-rays intraoral - comprehensive series (including bitewings) limited to once per provider every 24 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

Code	Service	Member Copayment
D0322	Tomographic survey limited to twice in a 12-month period	No Charge
D0330	Panoramic film limited to once in a 36-month period per provider, except when documented as essential for a follow-up/post-operative exam (such as after oral surgery)	No Charge
D0340	2D cephalometric radiographic image limited to twice in a 12-month period per provider	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally 1st limited to a maximum of 4 per date of service	No Charge
D0396	3D printing of a 3D dental surface scan	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	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

Code	Service	Member Copayment
D0801	3D intraoral 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
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
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

Code	Service	Member Copayment
D1527	Space maintainer - removable – bilateral, mandibular	No Charge
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No Charge
D1553	Re-cement or re-bond 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	\$25
D2140	Amalgam - one surface, permanent limited to once in a 36-month period	\$25
D2150	Amalgam - two surfaces, primary limited to once in a 12-month period	\$30
D2150	Amalgam - two surfaces, permanent limited to once in a 36-month period	\$30
D2160	Amalgam - three surfaces, primary limited to once in a 12-month period	\$40
D2160	Amalgam - three surfaces, permanent limited to once in a 36-month period	\$40
D2161	Amalgam - four or more surfaces, primary limited to once in a 12-month period	\$45
D2161	Amalgam - four or more surfaces, permanent limited to once in a 36-month period	\$45
D2330	Resin-based composite - one surface, anterior, primary limited to once in a 12-month period	\$30
D2330	Resin-based composite - one surface, anterior, permanent limited to once in a 36-month period	\$30

Code	Service	Member Copayment
D2331	Resin-based composite - two surfaces, anterior primary limited to once in a 12-month period	\$45
D2331	Resin-based composite - two surfaces, anterior permanent limited to once in a 36-month period	\$45
D2332	Resin-based composite - three surfaces, anterior primary limited to once in a 12-month period	\$55
D2332	Resin-based composite - three surfaces, anterior permanent limited to once in a 36-month period	\$55
D2335	Resin-based composite - four or more surfaces(anterior) primary limited to once in a 12-month period	\$60
D2335	Resin-based composite - four or more surfaces (anterior) permanent limited to once in a 36-month period	\$60
D2390	Resin-based composite crown, anterior, primary limited to once in a 12-month period	\$50
D2390	Resin-based composite crown, anterior, permanent limited to once in a 36-month period	\$50
D2391	Resin-based composite - one surface, posterior primary limited to once in a 12-month period	\$30
D2391	Resin-based composite - one surface, posterior permanent limited to once in a 36-month period	\$30
D2392	Resin-based composite - two surfaces, posterior; primary limited to once in a 12-month period	\$40
D2392	Resin-based composite - two surfaces, posterior; permanent limited to once in a 36-month period	\$40
D2393	Resin-based composite - three surfaces, posterior; primary limited to once in a 12-month period	\$50
D2393	Resin-based composite - three surfaces, posterior; permanent limited to once in a 36-month period	\$50
D2394	Resin-based composite - four or more surfaces, posterior; primary limited to once in a 12-month period	\$70
D2394	Resin-based composite - four or more surfaces, posterior; permanent limited to once in a 36-month period	\$70
D2710	Crown - resin-based composite (indirect) limited to once in a 5-year period	\$140

Code	Service	Member Copayment
D2712	Crown - $\frac{3}{4}$ resin-based composite (indirect) limited to once in a 5-year period	\$190
D2721	Crown - resin with predominantly base metal limited to once in a 5-year period	\$300
D2740	Crown - porcelain/ceramic limited to once in a 5-year period	\$300
D2751	Crown - porcelain fused to predominantly base metal limited to once in a 5-year period	\$300
D2781	Crown - $\frac{3}{4}$ cast predominantly base metal limited to once in a 5-year period	\$300
D2783	Crown - $\frac{3}{4}$ porcelain/ceramic limited to once in a 5-year period	\$310
D2791	Crown - full cast predominantly base metal limited to once in a 5-year period	\$300
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration limited to once in a 12-month period	\$25
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	\$25
D2920	Recement or re-bond crown	\$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	\$45
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	\$120
D2929	Prefabricated porcelain/ceramic crown - primary tooth limited to once in a 12-month period	\$95
D2930	Prefabricated stainless steel crown - primary tooth limited to once in a 12-month period	\$65
D2931	Prefabricated stainless steel crown - permanent tooth limited to once in a 36-month period	\$75
D2932	Prefabricated resin crown, primary limited to once in a 12-month period	\$75
D2932	Prefabricated resin crown, permanent limited to once in a 36-month period	\$75
D2933	Prefabricated stainless steel crown with resin window, primary limited to one in a 12-month period	\$80

Code	Service	Member Copayment
D2933	Prefabricated stainless steel crown with resin window, permanent limited to once in a 36-month period	\$80
D2940	Placement of interim direct restoration limited to once per tooth in a 12-month period	\$25
D2949	Restorative foundation for an indirect restoration	\$45
D2950	Core buildup, including any pins when required	\$20
D2951	Pin retention - per tooth, in addition to restoration	\$25
D2952	Post and core in addition to crown, indirectly fabricated limited to once per tooth regardless of number of posts placed	\$100
D2953	Each additional indirectly fabricated post - same tooth	\$30
D2954	Prefabricated post and core in addition to crown limited to once per tooth regardless of number of posts placed	\$90
D2955	Post removal	\$60
D2957	Each additional prefabricated post - same tooth	\$35
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	\$35
D2976	Band stabilization - per tooth	\$40
D2980	Crown repair necessitated by restorative material failure, by report. Limited to laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.	\$50
D2989	Excavation of a tooth resulting in the determination of nonrestorability	\$50
D2991	Application of hydroxyapatite regeneration medicament - per tooth	No Charge
D2999	Unspecified restorative procedure, by report	\$40
Endodontics		
D3110	Pulp cap - direct (excluding final restoration)	\$20
D3120	Pulp cap - indirect (excluding final restoration)	\$25
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament limited to once per primary tooth	\$40

Code	Service	Member Copayment
D3221	Pulpal debridement primary and permanent teeth	\$40
D3222	Partial pulpotomy for apexogenesis, permanent tooth with incomplete root development limited to once per permanent tooth	\$60
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) limited to once per primary tooth	\$55
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) limited to once per primary tooth	\$55
D3310	Endodontic (root canal) therapy, anterior (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	\$195
D3320	Endodontic (root canal) therapy, premolar (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	\$235
D3330	Endodontic (root canal) therapy, molar tooth (excluding final restoration) limited to once per tooth for initial root canal therapy treatment	\$300
D3331	Treatment of root canal obstruction; nonsurgical access	\$50
D3333	Internal root repair of perforation defects	\$80
D3346	Retreatment of previous root canal therapy - anterior	\$240
D3347	Retreatment of previous root canal therapy - premolar	\$295
D3348	Retreatment of previous root canal therapy - molar	\$350
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.) limited to once per permanent tooth	\$85
D3352	Apexification/recalcification - interim medication replacement only following D3351. Limited to once per permanent tooth	\$45
D3410	Apicoectomy - anterior	\$240
D3421	Apicoectomy - premolar (first root)	\$250
D3425	Apicoectomy - molar (first root)	\$275
D3426	Apicoectomy (each additional root)	\$110
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	\$350

Code	Service	Member Copayment
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	\$350
D3430	Retrograde filling - per root	\$90
D3431	Biologic materials to aid in soft and osseous tissue regeneration, in conjunction with periradicular surgery	\$80
D3471	Surgical repair of root resorption - anterior	\$160
D3472	Surgical repair of root resorption – premolar	\$160
D3473	Surgical repair of root resorption – molar	\$160
D3910	Surgical procedure for isolation of tooth with rubber dam	\$30
D3999	Unspecified endodontic procedure, by report	\$100
Periodontics		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth-bounded spaces per quadrant - once per quadrant every 36 months	\$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth-bounded spaces per quadrant - once per quadrant every 36 months	\$50
D4249	Clinical crown lengthening - hard tissue	\$165
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth-bounded spaces per quadrant - once per quadrant every 36 months	\$265
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth-bounded spaces per quadrant - once per quadrant every 36 months	\$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	\$80
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - once per quadrant every 24 months	\$55
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - once per quadrant every 24 months	\$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$40

Code	Service	Member Copayment
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	\$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	\$10
D4910	Periodontal maintenance limited to once in a calendar quarter	\$30
D4920	Unscheduled dressing change (by someone other than treating dentist), once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)	\$15
D4999	Unspecified periodontal procedure, by report	\$350
Prosthodontics, removable		
D5110	Complete denture - maxillary limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	\$300
D5120	Complete denture - mandibular limited to once in a 5-year period from a previous complete, immediate or overdenture- complete denture	\$300
D5130	Immediate denture - maxillary	\$300
D5140	Immediate denture - mandibular	\$300
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	\$300
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	\$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	\$335

Code	Service	Member Copayment
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) limited to once in a 5-year period	\$335
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$275
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	\$275
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$330
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$330
D5410	Adjust complete denture - maxillary limited to once per date of service; twice in a 12-month period	\$20
D5411	Adjust complete denture - mandibular limited to once per date of service; twice in a 12-month period	\$20
D5421	Adjust partial denture - maxillary limited to once per date of service; twice in a 12-month period	\$20
D5422	Adjust partial denture - mandibular limited to once per date of service; twice in a 12-month period	\$20
D5511	Repair broken complete denture base, mandibular	\$40
D5512	Repair broken complete denture base, maxillary	\$40
D5520	Replace missing or broken teeth - complete denture per tooth limited to a maximum of four, per arch, per date of service; twice per arch in a 12-month period	\$40
D5611	Repair resin denture base, mandibular	\$40
D5612	Repair resin denture base, maxillary	\$40
D5621	Repair cast framework, mandibular	\$40
D5622	Repair cast framework, maxillary	\$40
D5630	Repair or replace broken retentive/clasping materials- per tooth - limited to a maximum of three, per date of service; twice per arch in a 12-month period	\$50

Code	Service	Member Copayment
D5640	Replace missing or broken teeth - partial denture - per tooth - limited to maximum of four, per arch, per date of service; twice per arch in a 12-month period	\$35
D5650	Add tooth to existing partial denture limited - per tooth - to a maximum of three, per date of service; once per tooth	\$35
D5660	Add clasp to existing partial denture - per tooth - limited to a maximum of three, per date of service; twice per arch in a 12-month period	\$60
D5730	Reline complete maxillary denture (chairside) limited to once in a 12-month period	\$60
D5731	Reline complete mandibular denture (chairside) limited to once in a 12-month period	\$60
D5740	Reline maxillary partial denture (chairside) limited to once in a 12-month period	\$60
D5741	Reline mandibular partial denture (chairside) limited to once in a 12-month period	\$60
D5750	Reline complete maxillary denture (laboratory) limited to once in a 12-month period	\$90
D5751	Reline complete mandibular denture (laboratory) limited to once in a 12-month period	\$90
D5760	Reline maxillary partial denture (laboratory) limited to once in a 12-month period	\$80
D5761	Reline mandibular partial denture (laboratory) limited to once in a 12-month period	\$80
D5850	Tissue conditioning, maxillary limited to twice per prosthesis in a 36-month period	\$30
D5851	Tissue conditioning, mandibular maxillary limited to twice per prosthesis in a 36-month period. Not a benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.	\$30
D5862	Precision attachment, by report	\$90
D5863	Overdenture - complete maxillary - natural tooth borne	\$300

Code	Service	Member Copayment
D5864	Overdenture - partial maxillary - natural tooth borne	\$300
D5865	Overdenture - complete mandibular - natural tooth borne	\$300
D5866	Overdenture - partial mandibular - natural tooth borne	\$300
D5899	Unspecified removable prosthodontic procedure, by report	\$350
Maxillofacial Prosthetics		
D5909	Maxillary guidance prosthesis with guide flange	\$350
D5911	Facial moulage (sectional)	\$285
D5912	Facial moulage (complete)	\$350
D5913	Nasal prosthesis	\$350
D5914	Auricular prosthesis	\$350
D5915	Orbital prosthesis	\$350
D5916	Ocular prosthesis	\$350
D5919	Facial prosthesis	\$350
D5922	Nasal septal prosthesis	\$350
D5923	Ocular prosthesis, interim	\$350
D5924	Cranial prosthesis	\$350
D5925	Facial augmentation implant prosthesis	\$200
D5926	Nasal prosthesis, replacement	\$200
D5927	Auricular prosthesis, replacement	\$200
D5928	Orbital prosthesis, replacement	\$200
D5929	Facial prosthesis, replacement	\$200
D5930	Maxillary guidance prosthesis without guide flange	\$350
D5931	Obturator prosthesis, surgical	\$350
D5932	Obturator prosthesis, definitive	\$350
D5933	Obturator prosthesis, modification limited to twice in a 12-month period	\$150
D5934	Mandibular guidance prosthesis with guide flange	\$350
D5935	Mandibular guidance prosthesis without guide flange	\$350

Code	Service	Member Copayment
D5936	Obturator prosthesis, interim	\$350
D5937	Trismus appliance (not for TMD treatment)	\$85
D5938	Resection prosthesis, maxillary complete removable	\$350
D5939	Resection prosthesis, mandibular complete removable	\$350
D5940	Resection prosthesis, maxillary partial removable	\$350
D5941	Resection prosthesis, mandibular partial removable	\$350
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	\$350
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	\$350
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	\$350
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	\$350
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	\$350
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	\$350
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	\$350
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	\$350
D5951	Feeding aid	\$135
D5952	Speech aid prosthesis, pediatric	\$350
D5953	Speech aid prosthesis, adult	\$350
D5954	Palatal augmentation prosthesis	\$135
D5955	Palatal lift prosthesis, definitive	\$350
D5958	Palatal lift prosthesis, interim	\$350
D5959	Palatal lift prosthesis, modification limited to twice in a 12-month period	\$145

Code	Service	Member Copayment
D5960	Speech aid prosthesis, modification limited to twice in a 12-month period	\$145
D5982	Surgical stent for soft tissue healing	\$70
D5983	Radiation carrier	\$55
D5984	Radiation shield	\$85
D5985	Radiation cone locator	\$135
D5986	Fluoride gel carrier	\$35
D5987	Commissure splint	\$85
D5988	Surgical splint	\$95
D5991	Vesiculobullous disease medicament carrier	\$70
D5999	Unspecified maxillofacial prosthesis, by report	\$350
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	\$350
D6011	Surgical access to an implant body (second stage implant surgery)	\$350
D6012	Surgical placement of interim implant body for transitional prosthesis; endosteal implant	\$350
D6013	Surgical placement of mini-implant	\$350
D6040	Surgical placement: eposteal implant	\$350
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	\$35
D6050	Surgical placement: transosteal implant	\$350
D6055	Connecting bar - implant supported or abutment supported	\$350
D6056	Prefabricated abutment - includes modification and placement	\$135
D6057	Custom fabricated abutment - includes placement	\$180
D6058	Abutment supported porcelain/ceramic crown	\$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$315

Code	Service	Member Copayment
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$300
D6062	Abutment supported cast metal crown (high noble metal)	\$315
D6063	Abutment supported cast metal crown (predominantly base metal)	\$300
D6064	Abutment supported cast metal crown (noble metal)	\$315
D6065	Implant supported porcelain/ceramic crown	\$340
D6066	Implant supported crown (porcelain fused to high noble alloys)	\$335
D6067	Implant supported crown (high noble alloys)	\$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$320
D6075	Implant supported retainer for ceramic FPD	\$335
D6076	Implant supported retainer for FPD (porcelain fused to high noble alloys)	\$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	\$350
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	\$30

Code	Service	Member Copayment
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	\$30
D6082	Implant supported crown - porcelain fused to predominantly base alloys	\$335
D6083	Implant supported crown - porcelain fused to noble alloys	\$335
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	\$335
D6085	Interim implant crown	\$300
D6086	Implant supported crown - predominantly base alloys	\$340
D6087	Implant supported crown - noble alloys	\$340
D6088	Implant supported crown - titanium and titanium alloys	\$340
D6089	Accessing and retorquing loose implant screw - per screw	\$60
D6090	Repair of implant/abutment supported prosthesis	\$65
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	\$40
D6092	Recement implant/abutment supported crown	\$25
D6093	Recement implant/abutment supported fixed partial denture	\$35
D6094	Abutment supported crown - titanium and titanium alloys	\$295
D6096	Removal of broken implant retaining screw	\$60
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	\$315
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	\$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	\$330
D6100	Surgical removal of implant body	\$110

Code	Service	Member Copayment
D6105	Removal of implant body not requiring bone removal or flap elevation	\$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	\$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	\$350
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	\$350
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	\$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	\$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	\$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	\$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	\$350
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	\$350
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	\$350
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	\$330
D6121	Implant supported retainer for metal FPD - predominantly base alloys	\$350
D6122	Implant supported retainer for metal FPD - noble alloys	\$350
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	\$350
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	\$30
D6190	Radiographic/surgical implant index, by report	\$75
D6191	Semi-precision abutment – placement	\$350
D6192	Semi-precision attachment – placement	\$350

Code	Service	Member Copayment
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	\$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	\$315
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	\$95
D6198	Remove interim implant component	\$110
D6199	Unspecified implant procedure, by report	\$350
Prosthodontics, fixed		
D6211	Pontic - cast predominantly base metal limited to once in a 5-year period	\$300
D6241	Pontic - porcelain fused to predominantly base metal limited to once in a 5-year period	\$300
D6245	Pontic - porcelain/ceramic limited to once in a 5-year period	\$300
D6251	Pontic - resin with predominantly base metal limited to once in a 5-year period	\$300
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	\$20
D6721	Retainer crown - resin predominantly base metal - denture limited to once in a 5-year period	\$300
D6740	Retainer crown - porcelain/ceramic limited to once in a 5-year period	\$300
D6751	Retainer crown - porcelain fused to predominantly base metal limited to once in a 5-year period	\$300
D6781	Retainer crown - $\frac{3}{4}$ cast predominantly base metal limited to once in a 5-year period	\$300
D6783	Retainer crown - $\frac{3}{4}$ porcelain/ceramic limited to once in a 5-year period	\$300
D6784	Retainer crown - $\frac{3}{4}$ titanium and titanium alloys	\$300
D6791	Retainer crown - full cast predominantly base metal limited to once in a 5-year period	\$300

Code	Service	Member Copayment
D6930	Recement or re-bond fixed partial denture	\$40
D6980	Fixed partial denture repair necessitated by restorative material failure	\$95
D6999	Unspecified fixed prosthodontic procedure, by report	\$350
Oral Maxillofacial Prosthetics		
D7111	Extraction, coronal remnants - primary tooth	\$40
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	\$120
D7220	Removal of impacted tooth - soft tissue	\$95
D7230	Removal of impacted tooth - partially bony	\$145
D7240	Removal of impacted tooth - completely bony	\$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$175
D7250	Removal of residual tooth roots (cutting procedure)	\$80
D7252	Partial extraction for immediate implant placement	\$80
D7259	Nerve dissection	\$280
D7260	Oroantral fistula closure	\$280
D7261	Primary closure of a sinus perforation	\$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - limited to once per arch regardless of the number of teeth involved; permanent anterior teeth only	\$185
D7280	Exposure of an unerupted tooth	\$220
D7283	Placement of device to facilitate eruption of impacted tooth	\$85
D7284	Excisional biopsy of minor salivary glands	\$115
D7285	Incisional biopsy of oral tissue - hard (bone, tooth) limited to removal of the specimen only; once per arch per date of service	\$180

Code	Service	Member Copayment
D7286	Incisional biopsy of oral tissue - soft limited to removal of the specimen only; up to a maximum of 3 per date of service	\$110
D7290	Surgical repositioning of teeth; permanent teeth only; once per arch for patients in active orthodontic treatment	\$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report limited to once per arch for patients in active orthodontic treatment	\$80
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant. A benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.	\$85
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	\$50
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	\$120
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant	\$65
D7340	Vestibuloplasty - ridge extension (secondary epithelialization) limited to once in a 5-year period per arch	\$350
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) limited to once per arch	\$350
D7410	Excision of benign lesion up to 1.25 cm	\$75
D7411	Excision of benign lesion greater than 1.25 cm	\$115
D7412	Excision of benign lesion, complicated	\$175
D7413	Excision of malignant lesion up to 1.25 cm	\$95
D7414	Excision of malignant lesion greater than 1.25 cm	\$120
D7415	Excision of malignant lesion, complicated	\$255
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	\$105
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	\$185

Code	Service	Member Copayment
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$330
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$155
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$40
D7471	Removal of lateral exostosis (maxilla or mandible) limited to once per quadrant for the removal of buccal or facial exostosis only	\$140
D7472	Removal of torus palatinus limited to once in a patient's lifetime	\$145
D7473	Removal of torus mandibularis limited to once per quadrant	\$140
D7485	Surgical reduction of osseous tuberosity limited to once per quadrant	\$105
D7490	Radical resection of maxilla or mandible	\$350
D7509	Marsupialization of odontogenic cyst	\$180
D7510	Incision and drainage of abscess - intraoral soft tissue limited to once per quadrant, same date of service	\$70
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) limited to once per quadrant, same date of service	\$70
D7520	Incision and drainage of abscess - extraoral soft tissue	\$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue limited to once per date of service	\$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system limited to once per date of service	\$75

Code	Service	Member Copayment
D7550	Partial ostectomy/sequestrectomy for removal of nonvital bone limited to once per quadrant per date of service	\$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$235
D7610	Maxilla - open reduction (teeth immobilized, if present)	\$140
D7620	Maxilla - closed reduction (teeth immobilized, if present)	\$250
D7630	Mandible - open reduction (teeth immobilized, if present)	\$350
D7640	Mandible - closed reduction (teeth immobilized, if present)	\$350
D7650	Malar and/or zygomatic arch - open reduction	\$350
D7660	Malar and/or zygomatic arch - closed reduction	\$350
D7670	Alveolus - closed reduction, may include stabilization of teeth	\$170
D7671	Alveolus - open reduction, may include stabilization of teeth	\$230
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	\$350
D7710	Maxilla - open reduction	\$110
D7720	Maxilla - closed reduction	\$180
D7730	Mandible - open reduction	\$350
D7740	Mandible - closed reduction	\$290
D7750	Malar and/or zygomatic arch - open reduction	\$220
D7760	Malar and/or zygomatic arch - closed reduction	\$350
D7770	Alveolus - open reduction stabilization of teeth	\$135
D7771	Alveolus, closed reduction stabilization of teeth	\$160
D7780	Facial bones - complicated reduction with fixation and multiple approaches	\$350
D7810	Open reduction of dislocation	\$350
D7820	Closed reduction of dislocation	\$80
D7830	Manipulation under anesthesia	\$85

Code	Service	Member Copayment
D7840	Condylectomy	\$350
D7850	Surgical discectomy, with/without implant	\$350
D7852	Disc repair	\$350
D7854	Synovectomy	\$350
D7856	Myotomy	\$350
D7858	Joint reconstruction	\$350
D7860	Arthrotomy	\$350
D7865	Arthroplasty	\$350
D7870	Arthrocentesis	\$90
D7871	Nonarthroscopic lysis and lavage	\$150
D7872	Arthroscopy - diagnosis, with or without biopsy	\$350
D7873	Arthroscopy - lavage and lysis of adhesions	\$350
D7874	Arthroscopy - disc repositioning and stabilization	\$350
D7875	Arthroscopy - synovectomy	\$350
D7876	Arthroscopy - discectomy	\$350
D7877	Arthroscopy - debridement	\$350
D7880	Occlusal orthotic device, by report	\$120
D7881	Occlusal orthotic device adjustment	\$30
D7899	Unspecified TMD therapy, by report	\$350
D7910	Suture of recent small wounds up to 5 cm	\$35
D7911	Complicated suture - up to 5 cm	\$55
D7912	Complicated suture - greater than 5 cm	\$130
D7920	Skin graft (identify defect covered, location and type of graft)	\$120
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	\$80
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	\$350
D7940	Osteoplasty - for orthognathic deformities	\$160
D7941	Osteotomy - mandibular rami	\$350

Code	Service	Member Copayment
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	\$350
D7944	Osteotomy - segmented or subapical	\$275
D7945	Osteotomy - body of mandible	\$350
D7946	LeFort I (maxilla - total)	\$350
D7947	LeFort I (maxilla - segmented)	\$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	\$350
D7949	LeFort II or LeFort III - with bone graft	\$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or maxilla - autogenous or nonautogenous, by report	\$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$290
D7952	Sinus augmentation via a vertical approach	\$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	\$200
D7961	Buccal/labial frenectomy (frenulectomy)	\$120
D7962	Lingual frenectomy (frenulectomy)	\$120
D7963	Frenuloplasty limited to once per arch per date of service	\$120
D7970	Excision of hyperplastic tissue - per arch limited to once per arch per date of service	\$175
D7971	Excision of pericoronal gingiva	\$80
D7972	Surgical reduction of fibrous tuberosity limited to once per quadrant per date of service	\$100
D7979	Nonsurgical sialolithotomy	\$155
D7980	Surgical sialolithotomy	\$155
D7981	Excision of salivary gland, by report	\$120
D7982	Sialodochoplasty	\$215
D7983	Closure of salivary fistula	\$140
D7990	Emergency tracheotomy	\$350
D7991	Coronoidectomy	\$345
D7995	Synthetic graft - mandible or facial bones, by report	\$150

Code	Service	Member Copayment
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar limited to once per arch per date of service	\$60
D7999	Unspecified oral surgery procedure, by report	\$350
Orthodontics	Medically Necessary banded case (The Copayment applies to a Member's course of treatment as long as that Member remains enrolled in this Plan.)	\$1000
D8080	Comprehensive orthodontic treatment of the adolescent dentition handicapping malocclusion	
D8091	Comprehensive orthodontic treatment with orthognathic surgery	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	
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	

Code	Service	Member Copayment
Adjunctive General Services		
D9110	Palliative treatment of dental Pain - per visit	\$30
D9120	Fixed partial denture sectioning	\$95
D9210	Local anesthesia not in conjunction with operative or surgical procedures limited to once per date of service	\$10
D9211	Regional block anesthesia	\$20
D9212	Trigeminal division block anesthesia	\$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$15
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$45
D9222	Administration of deep sedation/general anesthesia - first 15-minute increment, or any portion thereof	\$45
D9223	Administration of deep sedation/general anesthesia - each subsequent 15-minute increment, or any portion thereof	\$45
D9224	Administration of general anesthesia with advanced airway - first 15-minute increment, or any portion thereof	\$65
D9225	Administration of general anesthesia with advanced airway - each subsequent 15-minute increment, or any portion thereof	\$65
D9230	Administration of nitrous oxide	\$15
D9239	Administration of moderate sedation - intravenous - first 15-minute increment, or any portion thereof	\$60
D9243	Administration of moderate sedation - intravenous - each subsequent 15-minute increment, or any portion thereof	\$60
D9244	In-office administration of minimal sedation – single drug – enteral	\$30
D9245	Administration of moderate sedation – enteral	\$65
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof	\$65

Code	Service	Member Copayment
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15-minute increment, or any portion thereof	\$65
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	\$135
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$20
D9440	Office visit - after regularly scheduled hours limited to once per date of service only with treatment that is a benefit	\$45
D9610	Therapeutic parenteral drug, single administration limited to a maximum of four injections per date of service	\$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	\$40
D9910	Application of desensitizing medicament limited to once in a 12-month period; permanent teeth only	\$20
D9930	Treatment of complications - post surgery, unusual circumstances, by report limited to once per date of service	\$35
D9950	Occlusion analysis - mounted case limited to once in a 12-month period	\$120
D9951	Occlusal adjustment - limited. Limited to once in a 12-month period per quadrant	\$45
D9952	Occlusal adjustment - complete. Limited to once in a 12-month period following occlusion analysis- mounted case (D9950)	\$210
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

Code	Service	Member Copayment
D9999	Unspecified adjunctive procedure, by report	No Charge

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

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 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 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 "Special Enrollment Periods for Newly Acquired Dependents" section below).
- Were mandated to be covered as a Dependent due to a valid state or federal court order.

- Demonstrate that you had a material provision of your health coverage contract substantially violated by your health coverage issuer.
- Were receiving services under another health benefit plan from a contracting provider, who is no longer participates in that health plan, for any of the following conditions: (a) an acute or serious condition; (b) a Terminal Illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contracts termination date or the Effective Date of coverage for a newly covered Member.
- Demonstrate to Covered California that you did not enroll in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage.
- Are a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code.
- Were not allowed to enroll in a plan through Covered California due to the intentional, inadvertent or erroneous actions of the Exchange.
- Gain or maintain status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act or are or become a Dependent of an Indian, and are enrolled in or are enrolling on the same application as the Indian (you can change from one plan to another one time per month).
- It is determined by Covered California on a case-by-case basis that the qualified individual or enrollee, or 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 policy.
- Lost medically needy coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium).
- Lost pregnancy-related coverage under Medi-Cal (not including voluntary termination or termination due to failure to pay premium).
- Gained access to new health benefit plans as a result of a permanent move.
- Were released from incarceration.
- Newly become a citizen or national of the United States or an alien lawfully present in the United States.
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a health benefit plan. Covered California must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for their employer's upcoming plan year to access this special enrollment period prior to the end of the coverage through the eligible employer-sponsored plan.
- 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.

Health Net requires proof no more frequently than once a year. 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 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 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.

If the mother is the Subscriber’s spouse and an enrolled Member, the child will be assigned to the mother’s Physician Group. If the mother is not enrolled, the child will be automatically assigned to the Subscriber’s Physician Group. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the “Transferring to Another Contracting Physician Group” portion of this section.

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

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

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

Legal Ward (Guardianship): If the Subscriber or spouse becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. You must enroll the child within 60 days of the effective date of the court order by submitting an enrollment application to Covered California and paying any applicable subscription charges. The child will be assigned to the Subscriber’s Physician Group. Coverage will begin on the first day of the month after Health Net receives the enrollment request. You must enroll the child by submitting a Newborn

Addition Form to Health Net and paying any applicable subscription charges. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the “Transferring to Another Physician Group” portion of this section.

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.

Transferring to Another Contracting Physician Group

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

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

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

Exception(s):

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

Effective Date of Transfer

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

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

For a newly eligible child who has been automatically assigned to a Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes

eligible. (Automatic assignment takes place with newborn and adopted children and is described in the “Who is Eligible and How to Enroll for Coverage” provision earlier in this section.)

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 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 Service Area, when the Family Member ceases to be eligible according to any other eligibility provisions of this health Plan, coverage will be terminated only for that person effective on midnight of the last day of the month, in which loss of eligibility occurred.
- c. When the Subscriber or Family Member ceases to reside in the Service Area, coverage will be terminated 30 days from the date the letter is mailed.

If a Member's coverage is terminated under this health Plan by Health Net for any reason noted above other than failure to pay subscription charges, a cancellation or nonrenewal notice will be sent at least 30 days prior to the termination which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice and (c) your right to submit a grievance. Once coverage is terminated, Health Net will send a termination notice which will provide the following information: (a) the reason for and effective date of the termination; (b) names of all enrollees affected by the notice and (c) your right to submit a grievance.

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

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

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

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 facts 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 canceled, 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:

- Health Net may revoke your coverage as if it never existed and you will lose health benefits including coverage for treatment already received;
- 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
- Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

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

COVERED SERVICES AND SUPPLIES

This Plan covers services or supplies provided from the Effective Date of coverage through midnight of the effective date of cancellation, except as specified in the “Extension of Benefits” portion of the “Eligibility, Enrollment and Termination” section. A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

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

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

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

Any Covered Benefit may require a Copayment, be subject to a Deductible, or have a benefit maximum. Please refer to the “Schedule of Benefits and Copayments” section for details.

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

Medical Services and Supplies

Office Visits

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

CVS MinuteClinic Services

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

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

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

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

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

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

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

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

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

CVS MinuteClinics may offer some services that are not covered by this Plan including, but not limited to, the following:

- Services required for the treatment of Emergency Services and Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit. Please refer to the “Schedule of Benefits and Copayments” section for applicable Copayment or Deductible requirements for all other services or supplies not covered under the CVS MinuteClinic benefit.
- Services or supplies obtained from a CVS MinuteClinic that are not specified as covered in this *Evidence of Coverage* are excluded under this Plan. CVS MinuteClinics are not intended to replace your Primary Care Physician or Specialist Physician as your primary source of regular monitoring of chronic conditions, but CVS MinuteClinics can, for example, provide a blood sugar test for diabetics, if needed.

For additional information about CVS MinuteClinics, please contact the Health Net Customer Contact Center at the telephone number on your Health Net ID card.

Preventive Care Services

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

Preventive Care Services are covered for children and adults, as directed by your Physician, based on recommendations by the California Department of Public Health (CDPH), and 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 (<https://www.cdc.gov/vaccines/imz-schedules/index.html>)
- Guidelines for infants, children and adolescents as supported by the Health Resources and Services Administration (HRSA). These recommendations are referred to as Bright Futures. (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)
- Guidelines for women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services is available through www.healthcare.gov/coverage/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), lung cancer, and colorectal cancer screening (e.g., colonoscopies)
- Breast cancer screening (mammograms, including three-dimensional (3D) mammography, also known as digital breast tomosynthesis). Additional breast imaging (e.g., MRI, ultrasound) and pathology evaluation is covered if additional imaging is indicated to complete the screening process
- Human Immunodeficiency Virus (HIV) testing and screening
- Pre-Exposure Prophylaxis (PrEP) medications for the prevention of HIV infection, including related medical services - baseline and follow-up testing and ongoing monitoring (e.g., HIV testing, kidney function testing, serologic testing for hepatitis B and C virus, testing for other sexually transmitted infections, pregnancy testing when appropriate and adherence counseling)
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthily, 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, 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; screening and counseling for intimate partner and domestic violence.

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

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

COVID-19 Outpatient Services

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

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

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

Vision and Hearing Examinations

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

Refractive Eye Surgery

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

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

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

You do not need Prior Authorization or a referral from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit our website at www.myhealthnetca.com or contact the Customer Contact Center at the phone 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 first contacting your Primary Care Physician or securing a referral from your Primary Care Physician. Reproductive and sexual Health Care Services include, but are not limited to, pregnancy services, including contraceptives and treatment; diagnosis and treatment of sexually transmitted disease (STD); medical care due to rape or sexual assault, including collection of medical evidence; and HIV testing.

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

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

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

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

Treatment Related to Rape or Sexual Assault

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

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

Immunizations and Injections

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

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

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

Surgical Services

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

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 Necessary.

Home Visit

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

Rehabilitation Therapy

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

Habilitative Services

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

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

Cardiac Rehabilitation Therapy

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

Approved Clinical Trials

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

“Routine patient care costs” are the costs associated with the requirements of Health Net, including drugs, items, devices and services that would normally be covered under this *Plan Contract and EOC*, if they were not provided in connection with an Approved Clinical Trials program.

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

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

Pulmonary Rehabilitation Therapy

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

Pregnancy

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

Prenatal diagnostic procedures include services provided by the California Prenatal Screening Program administered by the California Department of Public Health and are covered at no cost to the 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.

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

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.

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

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

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

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

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

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

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

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

Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered. See “Prostheses” in the “Schedule of Benefits and Copayments” for Copayment requirements and the “Covered Services and Supplies” section for additional information.

Note(s):

- 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.

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

Family Planning

This Plan covers counseling and planning for contraception, fitting examination for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of males and females is covered as described in the “Family Planning” portion of “Schedule of Benefits and Copayments.” Sterilization of females and contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. 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 and Copayments” section, as would be required for Covered Benefits to treat any illness or condition under this Plan.

Medical Social Services

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

Patient Education

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

Services for Educational or Training Purposes

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

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

Home Health Care Services

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

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

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

- The Member is 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, including any portion of shift care services. Private Duty Nursing (or shift care) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the “Definitions” section.

Outpatient Infusion Therapy

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

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

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

Covered 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. Only a 30-day supply will be dispensed per delivery.

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

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

- Any drug labeled “Caution, limited by Federal Law to Investigational use” or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA-approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA-approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including, but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Ambulance Services

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

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

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

- If Health Net determines that the ambulance or ambulance transport services were never performed; or
- If Health Net determines that the criteria for Emergency Services and Care were not met, unless authorized by your Physician Group; or
- Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the Plan, or that membership was invalid at the time services were delivered for the pending emergency claim.

Nonemergency ambulance and psychiatric transport van services are covered if a Physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

Members pay the same ground ambulance cost-sharing amount, regardless of whether the Covered Benefits are provided by a contracting or non-contracting ambulance provider.

Hospice Care

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

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

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

Durable Medical Equipment

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

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

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

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

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

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

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

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

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

For adults aged 19 and older, special contact lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic

contact lenses for that eye during the same Calendar Year. For children up to age 19, who are covered under pediatric vision services until the last day of the month in which they turn nineteen years of age, see “Pediatric Vision Services” portion of “Covered Services and Supplies” for coverage details.

This Plan does not cover the following items:

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

Please refer to the “Schedule of Benefits and Copayments” section for the applicable Copayment.

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

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

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including those listed below. The applicable diabetic equipment Copayment will apply, as shown in the “Schedule of Benefits and Copayments” 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 syringes*
- * These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the “Prescription Drugs” portion of this section for additional information.

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

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

Bariatric (Weight Loss) Surgery

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

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

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

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Member) to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of three (3) trips (work-up visit, the initial surgery and one follow-up visit).

- Hotel accommodations for the Member not to exceed \$100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Member) not to exceed \$100 per day, up to four (4) days for the Member's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

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

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

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

Treatment of Obesity

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

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

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

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

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

Renal Dialysis

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

Ostomy and Urological Supplies

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

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

Prostheses

Internal and external prostheses required to replace a body part are covered, including fitting and adjustment of such prostheses. Examples are artificial legs, surgically implanted hip joints, prostheses to

replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect, devices to restore speaking after a laryngectomy and visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

Prostheses to restore symmetry after a Medically Necessary mastectomy (including lumpectomy), and prostheses to restore symmetry and treat complications, including lymphedema, are covered.

Lymphedema wraps and garments are covered, as well as up to three brassieres in a 12-month period to hold a prosthesis.

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

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

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

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

Blood

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

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

Inpatient Hospital Confinement

Covered Benefits include:

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

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

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

Reconstructive Surgery

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

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

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

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

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

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

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

Outpatient Hospital Services

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

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

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

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

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

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

Dental Services

Dental services or supplies are limited to the following situations:

- When immediate Emergency Services and Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of the "Introduction to Health Net" section for more information.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily noncovered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this *Evidence of Coverage*, and will only be covered under the following circumstances (a) Members who are under eight years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.

- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- For acupuncture treatment of postoperative dental Pain, but only when Acupuncture Services are covered under this Plan through American Specialty Health Plans of California, Inc. (ASH Plans).

The following services are not covered under any circumstances, except as described above for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

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

Disorders of the Jaw

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

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

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

Skilled Nursing Facility

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

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

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

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

Phenylketonuria (PKU)

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

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

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

Vitamins and Nutritional Supplements

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

Second Opinion by a Physician

You have the right to request a second opinion when:

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

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

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

Surgically Implanted Drugs

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

Telehealth Services

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

Telehealth Consultations Through the Select Telehealth Services Provider

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

Telehealth consultations through the Select Telehealth Services Provider are confidential consultations by telephone or secure online video. The Select Telehealth Services Provider provides primary care

services and may be used when your Physician's office is closed, or you need quick access to a Physician or Participating Mental Health Professional. You do not need to contact your Primary Care Physician prior to using telehealth consultation services through the Select Telehealth Services Provider.

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

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

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

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

Prescription Drugs

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

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

Cost-sharing and any accrual of amounts from all drug coupons paid on your behalf for any Prescription Drugs obtained by you through the use of a drug discount, coupon, or copay card provided by a Prescription Drug manufacturer will not apply toward your Plan Deductible or Out-of-Pocket Maximum.

Covered Drugs and Supplies

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

Tier 1 Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs) and Tier 2 Drugs (nonpreferred Generic Drugs, preferred Brand Name Drugs, certain Brand Name Drugs with a generic equivalent or drugs recommended by the Pharmacy and Therapeutics Committee based on drug safety, efficacy and cost).

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

Tier 3 Drugs

Tier 3 Drugs consists of nonpreferred Brand Name Drugs or drugs that are recommended by the Health Care Service Plan'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 "Ambetter from Health Net 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 Ambetter from Health Net Drug List with "SP." Refer to Ambetter from Health Net's 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.

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

Generic Equivalents to Brand Name Drugs

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

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration; AND

2. The drug meets one of the following conditions:
 - a. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
 - b. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition, and the drug is either on the Ambetter from Health Net Drug List or Prior Authorization by Health Net has been obtained for such drug; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
 - a. The American Hospital Formulary Service Drug Information; OR
 - b. One of the following compendia, if recognized by the Federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
 - i. The Elsevier Gold Standard's Clinical Pharmacology.
 - ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - iii. The Thomson Micromedex DrugDex; OR
 - c. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal; AND
4. The drug is otherwise Medically Necessary.

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

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

Compounded Drugs

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

Diagnostic Drugs

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

Diabetic Drugs and Supplies

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

Drugs and Equipment for the Treatment of Asthma

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

Sexual Dysfunction Drugs

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

Preventive Drugs and Contraceptives

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

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

Covered contraceptives are FDA-approved contraceptives 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 Ambetter from Health Net 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 Services and Care, as defined under the “Definitions” section, will be covered when obtained from any licensed pharmacy, but must be obtained from a Plan contracted pharmacy if not required in conjunction with Emergency Services and Care as defined.

The Ambetter from Health Net Drug List

What Is the Health Net Ambetter from Health Net Drug List?

Health Net developed the Ambetter from Health Net 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 Ambetter from Health Net Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Ambetter from Health Net Drug List identifies whether a generic version of a Brand Name Drug exists and whether the drug requires Prior Authorization. If the generic version exists, it will be dispensed instead of the brand name version, unless you or your doctor requests the brand name version.

You may call the Customer Contact Center at the telephone number on your Health Net ID card to find out if a particular drug is listed in the Ambetter from Health Net 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 Ambetter from Health Net Drug List?

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

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

The committee is made up of actively practicing Physicians of various medical specialties from Health Net Physician Groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Ambetter from Health Net 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 Plan, you will not be required to use the step therapy process to continue using the Prescription Drug.

Step Therapy Exception

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

Prior Authorization and Step Therapy Exception Process for Prescription Drugs

Prior Authorization status is included in the Ambetter from Health Net Drug List. The Ambetter from Health Net 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 Ambetter from Health Net Drug List, your Physician should call Health Net to determine if the drug requires Prior Authorization.

Most Brand Name Drugs that have generic equivalents will require Prior Authorization to determine Medical Necessity. If approved for Medical Necessity, Health Net will cover Brand Name Drugs that

have generic equivalents when Medically Necessary and the Physician obtains approval from Health Net.

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

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

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

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

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy, please visit our website at www.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.

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

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

Health Net will reimburse you for the cost of the Prescription Drug, less any required Deductible and Copayment shown in the “Schedule of Benefits and Copayments” 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 Copayment or Deductible.

Pharmacy Lock-In Program

Health Net’s pharmacy benefit manager, 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 Ambetter from Health Net 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 Services and 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 Services and 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 covered expenses, less any required Deductible and Copayment shown in the “Schedule of Benefits and Copayments” section.

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

Except as specified in the “COVID-19 Outpatient Services” provision in this “Covered Services and Supplies” section, there are no benefits through Nonparticipating Pharmacies after 30 days of coverage

or if the Prescription Drug was not purchased for Emergency Services and Care or Urgently Needed Care.

Note(s):

- The “Prescription Drugs/Outpatient Prescription Drugs” portion of the “Exclusions and Limitations” section and the requirements of the Ambetter from Health Net Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.
- Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at www.myhealthnetca.com.

Drugs Dispensed by Mail Order

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

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

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

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

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

Note(s):

- Tier 4 (Specialty Drugs) and Schedule II narcotic drugs are not covered through our mail order program.

Mental Health or Substance Use Disorders

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

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

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

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

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

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

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.

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

If services under the proposed treatment plan are determined by Health Net to not be Medically Necessary, as defined in the "Definitions" section, services and supplies will not be covered for that condition. However, Health Net may direct you to community resources where alternative forms of assistance are available. See the "General Provisions" section for the procedure to request 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 or Substance Use Disorder services, visit our website at www.myhealthnetca.com or contact the Health Net Customer Contact Center phone number shown on your Health Net ID card.

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

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

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If

you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

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

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

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

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

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

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

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic Mental Health or Substance Use Disorder condition from a non-Participating Mental Health Professional at the time you enroll with Health Net, 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 non-Participating Mental Health Professional must be willing to accept Health Net's standard Mental Health or Substance Use Disorder provider contract terms and conditions and be located in the Plan's Service Area.

To request continued care for Mental Health or Substance Use Disorders, please call the Customer Contact Center at the telephone number on your Health Net ID card.

The following benefits are provided:

Outpatient Services

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

Covered Benefits include:

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

- o 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.
- o Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Note: All services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a Health Care Provider by the state of California. Examples of excluded services include education and training for nonmedical purposes such as:

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

Second Opinion

You may request a second opinion when:

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

To request an authorization for a second opinion, contact Health Net. Participating Mental Health Professionals will review your request in accordance with Health Net's second opinion policy. When

you request a second opinion, you will be responsible for any applicable Copayments. You may obtain a copy of this policy from the Customer Contact Center.

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

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

Inpatient Services

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

Covered Benefits include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary services in a Residential Treatment Center are covered. Admissions that are not considered Medically Necessary and are not covered include, but are not limited to, admissions for Custodial Care, for a situational or environmental change only; or as an alternative to placement in a foster home or halfway house.

Detoxification and Treatment 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.

Transitional Residential Recovery Services

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

Aversion Therapy

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

Psychological Testing

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

Biofeedback

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

Nonstandard Therapies

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

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

Treatment Related to Judicial or Administrative Proceedings

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

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

Pediatric Vision Services

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

The pediatric vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC to administer the pediatric vision services benefits.

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

All pediatric vision Covered Benefits must be provided by a Health Net Participating Vision Provider in order to receive benefits under this Plan. Call the pediatric vision services Customer Contact Center **1-866-392-6058** for a listing of Participating Vision Providers or visit our website at www.myhealthnetca.com. This Plan does not cover services and materials provided by a provider who is not a Participating Vision Provider. The Participating Vision Provider is responsible for the provision, direction and coordination of the Member’s complete vision care.

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

allowances specified in the “Pediatric Vision Services” portion of the “Schedule of Benefits and Copayments” section.

Examination

Routine optometric or ophthalmic vision examinations (including refractions) by a licensed optometrist or ophthalmologist, for the diagnosis and correction of vision, up to the maximum number of visits stated in the “Schedule of Benefits and Copayments” section. Vision examination includes dilation, if professionally indicated.

Contact Lens Fit and Follow-up Examination

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

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

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

Low Vision

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

Materials - Frames

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

Materials - Eyeglass Lenses

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

Cosmetic Contact Lenses

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

Medically Necessary Contact Lenses

Coverage for prescriptions for Medically Necessary contact lenses is subject to Medical Necessity.

Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

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

Subnormal or Low Vision Services and Aids: Health Net covers low vision services, supplemental testing/exam, Follow-Up Care, and aids, including high-power spectacles, magnifiers, and telescopes.

Contact Lenses for Conditions of Aphakia

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

Pediatric Dental Services

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

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

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

Choice of Provider

When you enroll, you must choose a selected general dentist from our network. Please refer to the *Directory of Participating Dentists* for a complete listing of selected general dentists.

Facilities

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

Medically Necessary Dental Services

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

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

New Patient and Routine Services

As a Member, you have the right to expect that the first available appointment time for new patient or routine dental care services is within four (4) weeks of your initial request. If your schedule requires that an appointment be scheduled on a specific date, day of the week, or time of day, the selected general dentist may need additional time to meet your special request.

Making an Appointment

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

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

Specialist Referrals

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

Orthodontic Benefits

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

Teledentistry Benefits

This dental Plan covers Medically Necessary Teledentistry benefits as described in the “Pediatric Dental Services” portion of the “Schedule of Benefits and Copayments.” Teledentistry services must be provided by a Participating Dentist from our network.

Referrals To Specialists for Orthodontic Care

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

Changing Your Selected General Dentist

You have control over your choice of dental offices, and you can make changes at any time. If you would like to change your selected general dentist, please contact Customer Service at **1-(866) 249-2382**. Our associates will help you locate a dental office most convenient to you. The transfer will be effective on the first day of the month following the transfer request. You must pay all outstanding charges owed to your dentist before you transfer to a new dentist. In addition, you may have to pay a fee for the cost of duplicating your x-rays and dental records.

Second Opinions

You may request a second opinion if you have unanswered questions about diagnosis, treatment plans, and/or the results achieved by such dental treatment. Contact our Customer Service Department either by calling Customer Service at **1-(866) 249-2382** or sending a written request to the following address:

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

Fax: 714-364-6266

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

- If you question the reasonableness or necessity of recommended surgical procedures.
- If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a Serious Chronic Condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating dentist is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

- If the treatment plan in progress is not improving your dental condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

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

Copayments

When you receive care from either a selected general dentist or Specialist, you will pay the Copayment described on your Schedule of Benefits and Copayments enclosed with this *Plan Contract and Evidence of Coverage*. When you are referred to a Specialist, your Copayment may be either a fixed dollar amount, or a percentage of the dentist's usual and customary fee. Please refer to the Schedule of Benefits and Copayments for specific details. When you have paid the required Copayment, if any, you have paid in full. If we fail to pay the contracted provider, you will not be liable to the provider for any sums owed by us. If you choose to receive services from a noncontracted provider, you may be liable to the noncontracted provider for the cost of services unless specifically authorized by us or in accordance with Emergency Services and Care provisions. We do not require claim forms.

Dental Customer Service

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your dental office. Customer Service can be reached Monday through Friday at **1-(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.

Acupuncture Services

Please read the “Acupuncture Services Exclusions and Limitations” portion of this 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.

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

Acupuncture Services Exclusions and Limitations

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

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

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

not covered. If you have a Life-Threatening or Seriously Debilitating condition and ASH plans denies coverage based on the determination that the therapy is experimental, you may be able to request an Independent Medical Review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

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

Auxiliary Aids

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

Diagnostic Radiology

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

Drugs

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

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

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

Experimental or Investigational Acupuncture Services

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

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Anesthesia

Charges for anesthesia are not covered.

Hypnotherapy

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

Noncontracted Providers

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

Acupuncture Services Not Listed under Acupuncture Services

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

Out-of-State Services

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

Thermography

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

Transportation Costs

Transportation costs are not covered, including local ambulance charges.

X-ray and Laboratory Tests

X-ray and laboratory tests are not covered.

Medically/Clinically Unnecessary Services

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

Services Not Within License

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

Vitamins

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

EXCLUSIONS AND LIMITATIONS

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

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

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

General Exclusions and Limitations

Acupuncture Services

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

Chiropractic Services

This Plan does not cover Chiropractic Services, except as required by law.

Clinical Trials

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

Coverage of Approved Clinical Trials does not include the following:

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

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

Cosmetic Services, Supplies, or Surgeries

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

by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this *EOC* in the “Covered Services and Supplies” section, or as required by law.

This exclusion does not apply to the following:

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

Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, or domiciliary care, which involves a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities, except as described in this *EOC* in the “Covered Services and Supplies” section or as required by law.

This exclusion does not apply to the following:

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

Dietary or Nutritional Supplements

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

Disposable Supplies for Home Use

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

Experimental or Investigational Services

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

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

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

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

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

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

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

Qualifications

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

External, Independent Review Process

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

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

DMHC's Independent Medical Review (IMR)

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

Hearing Aids

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

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP.

Immunizations

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

Nonlicensed or Noncertified Providers

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

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

Personal or Comfort Items

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

Prescription Drugs/Outpatient Prescription Drugs

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

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

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

Private Duty Nursing

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

Reversal of Voluntary Sterilization

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

Routine Physical Examination

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

Surrogate Pregnancy

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

Therapies

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

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

Travel and Lodging

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

Weight Control Programs and Exercise Programs

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

Dental Exclusions and Limitations

Adult Dental Services

This Plan does not cover dental services or supplies for Members age 19 and older, except as described in this *EOC* in the “Medically Necessary Dental Services” provision of the “Covered Services and Supplies” section or as provided as a supplemental benefit or as required by law.

Pediatric Dental Services

This Plan does not cover dental services or supplies for Members up to age 19, except as described in this *EOC* in the “Medically Necessary Dental Services” provision of the “Covered Services and Supplies” section of the *EOC* or as required by law. The exclusions and limitations for covered pediatric dental services are provided below.

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

Note(s):

- **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.**
- **Except as otherwise provided in the “Pediatric Dental Services” portion of “Covered Services and Supplies,” all benefits must be provided by the Member’s Primary Dentist in order to receive benefits under this dental Plan. This dental Plan does not provide benefits for services and supplies provided by a dentist who is not the Member’s Primary Dentist, except as specifically described under the “Pediatric Dental Services” portion of “Introduction to Health Net” section.**
- Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

Additional exclusions and limitations:**Implant Services (D6000-D6199)**

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

Medically Necessary Orthodontia (D8000-D8999)

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

- a. Only those cases with permanent dentition shall be considered for Medically Necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- b. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- c. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed Specialist on their professional letterhead.
- d. The automatic qualifying conditions are:
 - i. cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,

- ii. craniofacial anomaly. Written documentation from a credentialed Specialist shall be submitted, on their professional letterhead, with the Prior Authorization request,
- iii. a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
- iv. a crossbite of individual anterior teeth causing destruction of soft tissue,
- v. an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
- vi. a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the Prior Authorization request.

If a Member does not score 26 or above nor meets one of the six automatic qualifying conditions, 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;

- Palliative treatment (relief of Pain).
- Palliative (emergency) treatment, for treatment of dental Pain, limited to once per day, per Member.
- House/extended care facility calls, once per Member per date of service.
- One Hospital or ambulatory surgical center call per day per provider per Member.
- 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.
- Occlusal guards when Medically Necessary and Prior Authorized, for Members from 12 to 19 years of age when Member has permanent dentition.

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

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

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

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

Missed Appointments

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

Vision Exclusions and Limitations

Adult Vision Services

This Plan does not cover the following vision services for Members up to age 19, except as described in this *EOC* in the “Covered Services and Supplies” section or as provided as a supplemental benefit or as required by law. The exclusions and limitations for covered pediatric vision services are provided below.

Pediatric Vision Services

This Plan does not cover the following vision services for Members up to age 19, except as described in this *EOC* in the “Covered Services and Supplies” section or as required by law. The exclusions and limitations for covered pediatric vision services are provided below.

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

Note(s):

- **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. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames. See the “Pediatric Vision Services” portions of “Schedule of Benefits and Copayments” and “Covered Services and Supplies” for details.

Medical or Hospital

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

Loss or Theft

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

Orthoptics, Vision Training, etc.

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

Second Pair

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

Employment Related

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

Medical Records

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

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 Individual Products, P.O. 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 and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network HealthCare Provider.
- Certain accommodations for your disability, including
 - o Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
 - o Full and equal access, as other members of the public, to medical facilities.
 - o Extra time for visits if you need it.
 - o Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.

- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
 - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
 - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified HealthCare Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.

- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
 - Your Plan or Health Care Provider.
 - Any care you receive, or access to care you seek.
 - Any Covered Benefit or benefit decision that your Plan makes.
 - Any improper charges or bills for care.
 - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
 - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

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

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

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

- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of an individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your provider, before filing an arbitration proceeding, you must first file a grievance or appeal against Health Net by calling the Customer Contact Center at **1-888-926-4988** or by submitting a Member Grievance Form through the Health Net website at www.myhealthnetca.com.

You may also file your complaint in writing by sending information to:

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

If your concern involves the pediatric vision services, call Health Net at **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 Customer Service at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130-0569

If your concern involves the acupuncture program, call the Health Net Customer Contact Center at **1-888-926-4988** or write to:

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

For grievances filed for reasons other than cancellation, rescission or nonrenewal of coverage, you must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. For grievances filed regarding cancellation, rescission or nonrenewal of coverage, you must file your grievance with Health Net within 180 days of the termination notice. Please include all information from your Health Net 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 receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

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

Eligibility

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

- (A) Your provider has recommended a Health Care Service as Medically Necessary;
- (B) You have received urgent or Emergency Services and Care that a provider determined to have been Medically Necessary;
- (C) In the absence of the provider recommendation described in 1.(A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;
- (D) 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
- (E) You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review, you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

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

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

For more information regarding the IMR process or to request an application form, please call the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.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 or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request IMR of this denial.

Eligibility

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

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits you are entitled to. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on your Health Net ID card 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, EXCEPT AS THOSE DESCRIBED BELOW AND YOU AGREE NOT TO PURSUE ANY CLAIMS ON A CLASS ACTION BASIS. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between the parties and thereby the parties agree to forego any right they may have to a jury trial on such disputes.** However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *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 total amount of damages is over \$500,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

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

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

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

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

- **Refusal to Follow Treatment:** You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician, or the Physician Group. Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the Physician Group or at another Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.
- **Disruptive or Threatening Behavior:** You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.
- **Abusive Behavior:** You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, their office staff, the contracting Physician Group or Health Net personnel.
- **Inadequate Geographic Access to Care:** You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if it is determined that your residence is not within reasonable access to your current Primary Care Physician.

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

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

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 Benefits that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

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

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

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

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

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

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

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

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

STEPS YOU MUST TAKE

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

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

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

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

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

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

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

Contracting Physician Groups, Member Physicians, Hospitals and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital or other health care provider.

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

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other Hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the Effective Date of the contract termination.

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

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

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

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

To request continued care for medical services, 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.

If you need continued care for Mental Health or Substance Use Disorders, please contact the Customer Contact Center at the telephone number on your Health Net ID card.

Contracting Administrators

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

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

Decision-Making Authority

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

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

Health Net, in its role as a health maintenance organization, generally provides all Covered Benefits through a network of Physician Groups. Your Physician Group performs or authorizes all care, and you will not have to file claims.

There is an exception when you receive covered Emergency Services and Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

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

Benefits Not Transferable

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

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

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency Services and Care or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit and that you have filed as soon as was reasonably possible.

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

If you need to file a claim for medical or Mental Health or Substance Use Disorder Emergency Services and Care or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

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

If you need to file a claim for Outpatient Prescription Drugs, please send a completed Prescription 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 Customer Service at **1-866-249-2382** or write to:

Health Net
c/o Dental Benefit Providers of California, Inc.
P.O. Box 30567
Salt Lake City, Utah 84130

To be reimbursed for emergency pediatric dental services, you must notify Customer Service within forty-eight (48) hours after receiving such services. If your physical condition does not permit such notification, you must make the notification as soon as it is reasonably possible to do so. Please include your name, family ID number, address and telephone number on all requests for reimbursement.

Payment of Claim

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

Health Care Plan Fraud

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

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

Disruption of Care

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

If circumstances beyond Health Net's control result in you not being able to obtain the Medically Necessary Covered Benefits of this Plan, Health Net will make a good faith effort to provide or arrange

for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the “Emergency and Urgently Needed Care” section under the “Introduction to Health Net” section.

Transfer of Medical Records

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

Confidentiality of Medical Records

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

Notice of Privacy Practices

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

Effective: 01.01.2026

Covered Entities Duties:

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

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

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

- Uses or Disclosures;
- Your rights;
- Our legal duties;
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We are also committed to keeping your race, ethnicity, and language (REL), disability, sexual orientation and gender identity (SOGI), and social needs information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.

****This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities: Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved Rev. 03/11/26.***

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

Permissible Uses and Disclosures of Your PHI:

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

- ***Treatment*** - We may use or disclose your PHI to a Physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the Health Care Services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
 - o Processing claims;
 - o Determining eligibility or coverage for claims;
 - o Issuing premium billings;
 - o Reviewing services for Medical Necessity; and for
 - o 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:
 - o Providing customer services;
 - o Responding to complaints and appeals;
 - o Providing case management and care coordination;
 - o Conducting medical review of claims and other quality assessment; and
 - o 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 also have a relationship with you for its health care operations. This includes the following:

- o Quality assessment and improvement activities;
- o Reviewing the competence or qualifications of health care professionals;
- o Case management and care coordination; and
- o Detecting or preventing health care fraud and abuse.

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

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

This information helps us to:

- o Better understand your health care needs;
- o Know your language preference when seeing health care providers;
- o Providing health care information to meet your care needs; and
- o Offer programs to help you be your healthiest.

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

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

Other Permitted or Required Disclosures of Your PHI:

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

- ***Judicial and Administrative Proceedings*** – We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
 - o An order of a court;
 - o Administrative tribunal;
 - o Subpoena;
 - o Summons;
 - o Warrant;
 - o Discovery request; or
 - o 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:
 - o Court order;
 - o Court-ordered warrant;
 - o Subpoena;
 - o Summons issued by a judicial officer; or
 - o Grand jury subpoena.

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- ***Substance Use Disorder Records (SUD)*** – We will not use or disclose your SUD records in legal proceedings against you unless:
 - o We receive your written consent, or
 - o We receive a court order, you’ve been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal Document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors*** – We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
 - o Cadaveric organs;
 - o Eyes; and
 - o 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:
 - o To authorized federal officials for national security and intelligence activities;
 - o The Department of State for medical suitability determinations; and
 - o 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, disability, gender identity, and social needs information to deny coverage, services, benefits, or for underwriting purposes.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

The state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net, LLC) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of sex, race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, mental or physical disability, ethnic group identification or medical genetic information.

- ***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, form, format or to alternative locations. This request shall apply to all communication that disclose medical information (PHI) or provider name and address related to receipt of medical services by the individual requesting the confidential communication. We must accommodate your request if it is reasonable and specifies the alternative means, form, format, 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. Refer to the customer service phone number on the back of your Member identification card or the plan's website for instructions on how to request confidential communication.
- ***Right to Access and Receive Copy of Your PHI*** – You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend Your PHI*** – You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** – You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** – If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

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

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** – You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our website or by electronic mail (email), 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: 1-833-887-0151
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:

- on applications or other forms, such as name, address, age, Medical Information and Social Security number;
- your transactions with us, our affiliates or others, such as premium payment and claims history; and
- consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice:

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

Health Net, LLC
Attn: Privacy Official
21281 Burbank Blvd
Woodland Hills, CA 91367

Please **call the toll-free phone number on the back of your ID card** or contact Health Net at **1-888-926-4988**.

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Plan Contract* with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by ASH Plan to be Medically Necessary for the treatment of that condition. Acupuncture Services are typically provided only for the treatment of nausea or as part of a comprehensive Pain management program for the treatment of chronic Pain.

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Benefits shall be provided for the duration of the acute condition.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Ambetter from Health Net 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 Ambetter from Health Net Drug List require Prior Authorization from Health Net in order to be covered.

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.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
 - o The National Institutes of Health.
 - o The federal Centers for Disease Control and Prevention.
 - o The Agency for Healthcare Research and Quality.
 - o The federal Centers for Medicare and Medicaid Services.
 - o A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.

- o A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- o One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - The United States Department of Veterans Affairs.
 - The United States Department of Defense.
 - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Bariatric Surgery Performance Center is a provider in Health Net's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery.

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

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

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

Copayment is a fee charged to you for Covered Benefits when you receive them and can either be a fixed dollar amount or a percentage of Health Net's cost for the service or supply, agreed to in advance by Health Net and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The percentage Copayment is usually billed after the service is received. The Copayment for each Covered Benefit is shown in the "Schedule of Benefits and Copayments" section.

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

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under an individual or group agreement and which are described in this *Evidence of Coverage* or under California health plan law.

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

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;

- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which are designed to offer an alternative to a Physician's office visit for the unscheduled treatment of nonemergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

CVS MinuteClinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the state of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

Deductible is a set amount you pay each Calendar Year for specified covered expenses before Health Net pays any benefits for those covered expenses in that Calendar Year. Refer to the "Schedule of Benefits and Copayments" section 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 Service Area.

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

Durable Medical Equipment

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

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

Emergency Dental Care includes Medically Necessary services required for: (1) the alleviation of severe Pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions. However, payment for Emergency Dental Care rendered will be conditioned on Health Net's subsequent review and determination as to consistency with professionally recognized standards of dental practice and Health Net's dental policies.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe Pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

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 and Care, hospitalization, maternity and newborn care, Mental Health or 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.

Evidence of Coverage (EOC) means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

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

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Services and Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Services and Care or Urgently Needed Care.

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 Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a health care provider by the state of California to perform the services, acting within the scope of their license or as otherwise authorized under California law.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

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.

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

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

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

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

Life-Threatening means either or both of the following:

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

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

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

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

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Health Net Plan and for whom coverage is active or live.

Member Physician is a Physician who practices medicine as an associate of a Physician Group.

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

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

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

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

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

Out-of-Pocket Maximum is the maximum amount of Copayments and Deductibles you must pay for Covered Benefits for each Calendar Year.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, residential treatment center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with Health Net, to provide Mental Health or Substance Use Disorder benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or substance use disorder rehabilitation services.

Participating Dentist is a dentist or dental facility licensed to provide benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Dentists are set forth in Health Net's *Participating Dentist Directory*. The names of Participating Dentists and their locations and hours of practice may also be obtained by contacting Health Net's Customer Service Department. This Plan does not guarantee the initial or continued availability of any particular Participating Dentist.

Participating Mental Health Professional is a Physician or other professional who is licensed, certified or otherwise authorized by the state of California to provide mental Health Care Services. The

Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health or Substance Use Disorder services. See also “Qualified Autism Service Provider” below in this “Definitions” section.

Participating Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish such care to Members.

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

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Benefits and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net’s *Participating Vision Provider Directory*. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net’s Customer Contact Center.

Physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

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

Physician Group is the Health Net contracting medical group the individual Member selected as the source of all covered medical care. They are sometimes referred to as a “contracting Physician Group” or “Participating Physician Group (PPG).” Another common term is “a medical group.” An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by you and described in this *Plan Contract*.

Plan Contract 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.

Prescription Drug or “drug” means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term “drug” or “prescription drug” includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Health Net Plan’s prescription drug benefit.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Member Physician.

Preventive Care Services are services and supplies that are covered under the “Preventive Care Services” heading as shown in the “Schedule of Benefits and Copayments” section, and the “Covered Services and Supplies” section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health

- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician is a Member Physician who coordinates and controls the delivery of Covered Benefits and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

Primary Dentist is any Participating Dentist who has the responsibility for providing benefits to Members, maintaining the continuity of patient care, initiating referral for orthodontic care and who is listed in the current *Participating Dentist Directory* for your area as a Primary Dentist.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements not otherwise specified in this document, call the Customer Contact Center telephone number listed on your Health Net ID card. See "Prior Authorization Process for Prescription Drugs" in the "Prescription Drugs" portion of "Covered Services and Supplies" for details regarding the Prior Authorization process relating to Prescription Drugs.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or skilled nursing facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a 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 disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board with a certification, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive

developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional:
 - A. Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider;
 - B. Is supervised by a Qualified Autism Service Provider;
 - C. Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; and is either of the following:
 - 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;
 - F. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation

can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

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

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

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

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Subscriber is the person enrolled under this *Plan Contract* who is responsible for payment of premiums to Health Net and whose status is the basis for family member eligibility under this *Plan Contract*.

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 person (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 their own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in their body, but the egg is not their 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 Benefits shall be provided for the duration of a Terminal Illness.

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

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

Tier 3 Drugs include nonpreferred Brand Name Drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on 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 listed in the Ambetter from Health Net 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.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

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

LANGUAGE ASSISTANCE SERVICES

Health Net provides free language assistance services, such as in-person interpretation, telephone interpretation, video remote interpretation, sign language interpretation, translated written materials, oral translations and appropriate auxiliary aids for individuals with disabilities. Health Net's Customer Contact Center has bilingual/multilingual staff and interpreter services for additional languages to support Member language needs. Interpretation services in your language can be used for, but not limited to, explaining benefits, filing a grievance and answering questions related to your health plan. Also, our Customer Contact Center staff can help you find a health care provider who speaks your language. Call the Customer Contact Center number on your Health Net ID card for this free service and to schedule an interpreter. Providers may not request that you bring your own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a covered benefit or service is accessed. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for Health Care Services in such a manner that ensures the provision of interpreter services at the time of the appointment. Some types of interpretation must be scheduled before the appointment.

NOTICE OF LANGUAGE SERVICES

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք 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 고객센터 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 báqá'h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'íjį. Naaltsoos da t'áá shí shizaad k'éhjí shichí' yídooltah nínízingo t'áá ná ákódoolnííł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodiílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihi' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange: 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) ਐੱਫ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐੱਓਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੇਲ ਬਿਜਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленным 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 представленным 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 (โทรมา TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมา TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมา TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมา 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 On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

NONDISCRIMINATION NOTICE

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Health Net Customer Contact Center at

Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)

Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)

Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call one of the phone numbers above or write to:

Health Net

Post Office Box 9103, Van Nuys, California 91409-9103

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

- Electronically: Send an email to SM_Section1557Coord@centene.com This notice is available at Health Net website:
https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html

If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

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Contact us

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
1.888.926.4988

www.myhealthnetca.com

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