Evidence of Coverage and Plan Document

Effective January 1, 2027

Salud HMO y Más Basic Plan

Health Maintenance Organization (HMO)

Legislative and Administrative changes effective January 1, 2027 are not included in this document.

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

Dear Health Net Member:

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

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

If your Group has requested that we make it available, you can access this document online through Health Net's secure website at https://www.healthnet.com/calpers. You can also elect to have a hard copy of this *Evidence of Coverage* mailed to you by calling the Customer Contact Center at **1-888-926-4921**.

We look forward to serving you. Contact us at www.healthnet.com/calpers 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at **1-800-926-4921**. Our Customer Contact Center is available from 8:00 a.m. to 6:00 p.m., Monday through Sunday, except holidays.

This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

Thank you for choosing Health Net.

Schedule of Changes in 2027

This page is not an official statement of benefits. Your benefits are described in detail in the *Evidence of Coverage (EOC)*. We have also edited and clarified language throughout the Evidence of Coverage.

Changes to this Plan **Effective July 1, 2027**.

Family Planning -The following additional services are available and are subject to applicable Copayments and any exclusions and limitations of this Plan:

- Oocyte retrieval and embryo transfers
- In-vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Cryopreservation
- Surrogate pregnancy

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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.

This *Evidence of Coverage* constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

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

THERE IS NO VESTED RIGHT TO RECEIVE ANY PARTICULAR BENEFIT SET FORTH IN THE PLAN. PLAN BENEFITS MAY BE MODIFIED. ANY MODIFIED BENEFIT (SUCH AS THE ELIMINATION OF A PARTICULAR BENEFIT OR AN INCREASE IN THE MEMBER'S COPAYMENT) APPLIES TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF THE MODIFICATION.

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. You may request more information about our payment methods by contacting the Health Net Customer Contact Center at the telephone number on your Health Net ID card, your Physician Group, Sistemas Medicos Nacionales S.A. de C.V. (SIMNSA) or your Primary Care Physician.

Use of Special Words

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

The following words are used frequently:

- "**You**" or "**Your**" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- "**Employee**" has the same meaning as the word "you" above.
- "**We**" or "**Our**" refers to Health Net.
- "**Subscriber**" means the primary Member, generally an employee of a Group.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the medical group that provides or arranges for all Covered Benefits for Members. Physician Groups contracting with the Health Net Salud Network (Salud Network) provide Covered Benefits for Members in California. Sistemas Medicos Nacionales S.A. de C.V. (hereinafter referred to as SIMNSA) provides Covered Benefits for Members in Mexico. It may be referred to as a "Contracting Physician Group" or "Participating Physician Group (PPG)."
- "**Primary Care Physician**" is a Member Physician who provides or 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.
- "**Group**" is the business entity (usually an employer or Trust) that contracts with Health Net to provide this coverage to you.
- "**Plan**" and "*Evidence of Coverage*" (EOC) have similar meanings. You may think of these as meaning your Health Net benefits.
- "**SIMNSA Providers**" are providers operating in approved regions of Mexico. A Member who utilizes the services of a contracting Physician Group in Mexico will be using a SIMNSA Provider.
- "**Health Net Salud Network (Salud Network)**" is the network of contracting Physician Groups, Hospitals, ancillary providers and pharmacies that Health Net has established to provide care to Members who live or work within the Health Net Salud Service Area in California.

Please refer to the "Health Net Salud Plan Service Area" section at the end of this EOC to determine if you work or live in an area where this Salud Con Health Net Plan is available.

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INTRODUCTION TO HEALTH NET

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

This Salud con Health Net Plan is specifically designed for Groups located in the Health Net Salud Service Area. Please refer to the "Health Net Salud Service Area" section at the end of the EOC for more information on the approved areas of California and Mexico where this Salud Con Health Net Plan is available.

In order to enroll in this Plan, the Subscriber must:

- Meet the eligibility requirements of their Group;
- Live in California; and
- Live or work in the Health Net Salud Service Area.

How to Obtain Care

If you live in California
You may receive Covered Benefits in either California (from your Salud Network Provider) or in Mexico (from a SIMNSA Provider). When you enroll in this Plan, you must select a Salud Network Physician Group where you want to receive all of your medical care in California. That Physician Group will provide or authorize all medical care received in California. Call your Physician Group directly to make an appointment. For contact information on your Physician Group, please call the Customer Contact Center at the telephone number on your Health Net ID card. In Mexico you may go to any contracting Physician Group in the SIMNSA Network and are not required to select a particular SIMNSA Physician Group for Covered Benefits.

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 *Evidence of Coverage*.

If you live in Mexico (Family Members only) and your Employer group eligibility allows enrollment in this plan:
You must receive Covered Benefits from a SIMNSA Provider, except in the case of Emergency Services and Care or Urgently Needed Care.

The following chart will help you understand how to obtain care.

Members living in California

TYPE OF SERVICE	PROVIDED IN CALIFORNIA	PROVIDED IN MEXICO
PHYSICIANS*	Your Salud Network Physician Group (which you select when you enroll)	Any SIMNSA Participating Physician
HOSPITALS*	Salud Network Hospitals	SIMNSA Hospitals
ANCILLARY	Health Net Participating Providers	SIMNSA Participating Providers
PHARMACY	Pharmacy benefits are provided by CVS Caremark. Please see your CVS Caremark EOC for complete benefit details	SIMNSA Participating Pharmacy

SIMNSA Participating Pharmacy (when enrollment is allowed by the employer group)

Members living in Mexico (when enrollment is allowed by the employer group)

TYPE OF SERVICE	PROVIDED IN CALIFORNIA	PROVIDED IN MEXICO
PHYSICIANS*	Benefits are available only for Emergency Services and Care or Urgently Needed Care	Any SIMNSA Participating Physician
HOSPITALS*	Benefits are available only for Emergency Services and Care or Urgently Needed Care	SIMNSA Hospitals
ANCILLARY	Benefits are available only for Emergency Services and Care or Urgently Needed Care	SIMNSA Participating Providers
PHARMACY	Benefits are available only for Emergency Services and Care or Urgently Needed Care	SIMNSA Participating Pharmacy

*The benefits of this plan are only available for Covered Benefits received from either a Salud Network or SIMNSA Provider, except for the following: (1) Emergency Services and Care; (2) referrals to non-network providers when issued by your Salud Network or SIMNSA Physician Group; and (3) Covered Benefits provided by a non-network provider when authorized by Salud Network or SIMNSA. Please refer to the "Specialists and Referral Care" and "Emergency and Urgently Needed Care" provisions of this section for more details on referrals and how to obtain Emergency Services and Care.

Unless specifically stated otherwise, use of the following terms in this *Evidence of Coverage* refers to the Health Net Salud Network in California, and SIMNSA Network in Mexico, as explained above.

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

Please see the "Schedule of Benefits and Copayments" section for Covered Benefits.

Health Net and SIMNSA will distribute provider directories at the time of enrollment. Please call Health Net's Customer Contact Center or SIMNSA if you need a provider directory or if you have questions involving reasonable access to care. SIMNSA Members may contact SIMNSA at (011-52-664) 683-29-02 or 683-30-05 or 1-619-407-4082.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Evidence of Coverage and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at 1-888-926-4921 to ensure that you can obtain the Health Care Services that you need.

Health Net Salud Service Area
The Health Net Salud Service Area encompasses certain regions in Southern California and Mexico (Baja California within fifty miles of the California – Mexico Border).

Please refer to the "Health Net Salud Plan Service Area" section at the end of the EOC for more information on the approved areas of California and Mexico where this Salud Con Health Net Plan is available.

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

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the Effective Date of coverage under this Plan;
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A pregnancy including the duration of the pregnancy and immediate postpartum care;
- 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 the Member's 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 Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's 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, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care, or request a copy of the Continuity of Care Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID card or visit our website at www.healthnet.com/calpers.

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 this Primary Care Physician designation, Health Net designates one for you. Information on how to select a Primary Care Physician is available on the Health Net website at www.healthnet.com/calpers. A list of the participating Primary Care Physicians in the Health Net Service Area is also available on the Health Net website at www.healthnet.com/calpers. The provider directory is also available on the Health Net website at www.healthnet.com. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more. 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
At the time of enrollment, Subscribers and Family Members who live in California must select a Salud Network Physician Group close enough to their residence or place of work to allow reasonable access to medical care. Family Members may select different participating Physician Groups.

A Subscriber who resides outside the Health Net Salud Service Area may enroll based on the Subscriber's work address that is within the Health Net Salud Service Area. Family Members who reside outside the Health Net Salud Service Area may also enroll based on the Subscriber's work address that is within the Health Net Salud Service Area. If you choose a Physician Group based on its proximity to the Subscriber's work address, you will need to travel to that Physician Group for any nonemergency or nonurgent care that you receive. Additionally, some Physician Groups may decline to accept assignment of a Member whose home or work address is not close enough to the Physician Group to allow reasonable access to care. The provider directory allows you to find information on network providers including names, addresses, telephone numbers, specialties, and more. Subscribers and Family Members who live in California may also obtain Covered Benefits from SIMNSA Providers in Mexico.

When enrollment is allowed by the Employer group, family Members living in Mexico, may go to any contracting Physician Group in the SIMNSA Network and are not required to select a particular SIMNSA Physician Group for Covered Benefits. Such Family Members may not obtain any services in California, except in the case of Emergency Services and Care or Urgently Needed Care.

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

Routine outpatient therapy and medication management visits with an in-network provider do not require Prior Authorization nor referral from a Primary Care Physician. Certain services and supplies for Mental Health or Substance Use Disorders may require Prior Authorization by Health Net in order to be covered. Upon request, the criteria used to review the Prior Authorization request, and

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

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 your Physician cannot provide. At such times, in order to see a Specialist or other Health Care Provider for that care, you will need to have a referral. Refer to the "Selecting a Participating Mental Health Professional" section above for information about receiving care for Mental Health or Substance Use Disorders.

If you are a California Member and you need medical care that your Salud Network Physician Group cannot provide, your Physician Group may refer you to a Specialist or other Health Care Provider for that care. Your Salud Network Physician Group must authorize all treatments recommended by such provider.

Members in Mexico may self-refer to any provider in the SIMNSA Network in Mexico without Prior Authorization. You must receive authorization from SIMNSA to receive care from providers outside the SIMNSA Network, except in case of Emergency or Urgently Needed Care.

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 COVEREDBENEFIT.

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 Contracting Physician Groups
Subscribers and Dependents residing in California may, depending on the circumstances, transfer to another contracting Physician Group in the Salud Network. These transfers must be according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of the "Eligibility, Enrollment and Termination" section.

If enrollment is allowed Members residing in Mexico will not be required to select a contracting Physician Group; they may obtain care from any Physician provided they contract to participate in the SIMNSA Network.

Your Financial Responsibility
Your Salud Network or SIMNSA Provider will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Copayment described in the "Schedule of Benefits and Copayments" section.

You are completely financially responsible for medical care that is not provided or authorized by your Salud Network or SIMNSA Provider except for Medically Necessary care provided in an emergency. However, if you receive Covered Benefits at a contracted 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 a contracted network provider. You are also financially responsible for care that this Plan does not cover.

Questions
Call Health Net's Customer Contact Center or SIMNSA 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, a business day is Monday through Friday, and does not include weekends or holidays.

Scheduling Appointments with Your Primary Care Physician
When you need to see your Primary Care Physician (PCP), call their office for an appointment at the phone number on your Health Net ID card. Please call ahead as soon as possible. When you make an appointment, identify yourself as a Health Net Member, and tell 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, and tell them when you would like to see your provider. 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 does not require Prior Authorization:** within 48 hours of request.
- **Urgent care appointment with non-Physician behavioral Health Care Provider or behavioral health care Physician (psychiatrist) that requires Prior Authorization:** within 96 hours of request.
- **Nonurgent appointment with behavioral health care Physician (psychiatrist):** within 15 business days of request.
- **Nonurgent appointment with non-Physician behavioral Health Care Provider:** within 10 business days of request.
- **Nonurgent follow-up appointment with non-Physician mental Health Care Provider (NPMH):** within 10 business days of request.
- **Non-Life-Threatening behavioral health emergency:** within 6 hours of request for an appointment.
- 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 for emergency services in Mexico.

Note:
There is no "**911**" or similar emergency response system in Mexico, therefore, the "**911**" number is not applicable to emergency care in Mexico.

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.

If you are outside your Physician Group's Service Area: Go to the nearest medical center or Hospital, or call "**911**."

Your Salud Network, SIMNSA Providers and Health Net are available 24 hours a day, seven days a week, to respond to your phone calls regarding 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 SIMNSA Provider, 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, Health Net, or a SIMNSA Provider.

- **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 or SIMNSA to be performed by others. You may use nonparticipating mental health providers only when authorized by Health Net or SIMNSA.

Members are solely responsible for any U.S. Immigration and Naturalization Service documentation or authorization to enter the United States. Health Net is not responsible to assure access to Covered Benefits from its participating providers in the United States where the Member is not permitted to enter the United States to obtain such services because they have not obtained the necessary documentation or authorization from the U.S. Immigration and Naturalization Service. Members without such documentation and authorization will be required to receive all Covered Benefits through SIMNSA participating providers in Mexico.

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 Services and Care— Must be performed by your Salud Network Physician Group, a Participating Mental Health Professional or a SIMNSA Provider or be authorized by your Physician Group, Health Net, or SIMNSA in order to be covered. These services, if performed by others outside your Physician Group, our network of Participating Mental Health Professionals or SIMNSA, will not be covered unless they are authorized by your Physician Group, Health Net or SIMNSA.

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 other personnel to the extent permitted by applicable law and 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 Salud Network Provider (medical) or Health Net (Mental Health or Substance Use Disorders) in California or SIMNSA Provider in Mexico as soon as you can after receiving emergency services from others outside your Physician Group. Your Salud Network Physician (medical), Health Net (Mental Health or Substance Use Disorders), or SIMNSA Physician Group 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 the Health Care Provider regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician 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.

State Hospital Treatment: Services in a state Hospital are limited to treatment or confinement as the result of Emergency

Services and Care or Urgently Needed Care as defined in the "Definitions" section.

Follow-up Care services must be performed by a provider within the Salud Network or SIMNSA (medical) or a Participating Mental Health Professional or SIMNSA (Mental Health or Substance Use Disorders) and, if required, authorized by your Salud Network Physician Group (medical) or Health Net (Mental Health or Substance Use Disorders), or SIMNSA or they will not be covered.

Follow-up Care after Emergency Services and Care at a Hospital that is not contracted with the Salud Network or SIMNSA: If you are treated for Emergency Services and Care at a Hospital that is not contracted with the Salud Network or SIMNSA, Follow-Up Care must be authorized by Health Net or SIMNSA 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 or SIMNSA to obtain timely authorization. If Health Net or SIMNSA determines that you may be safely transferred to a Hospital that is contracted with the Salud Network or SIMNSA 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 or SIMNSA in order to request Prior Authorization, the noncontracted Hospital may bill you for such services.

For Employer groups that allow enrollment of Dependents who live in Mexico and are assigned to the SIMNSA Network, only Emergency Services and Care or Urgently Needed Care is covered in California.

Definitions Related to Emergency Services and Care and Urgently Needed Care
Please refer to the "Definitions" section of this *Evidence of Coverage*, for definitions of Emergency Services and Care, Emergency Medical Condition, Psychiatric Emergency Medical Condition and Urgently Needed Care.

Prescription Drugs
For Members living in Mexico assigned to the SIMNSA network. 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 reimburse you for the retail cost of the drug less any required 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 SIMNSA. Call SIMNSA at the telephone number on your Health Net ID card or visit our website at www.healthnet.com to obtain claim forms and information.

Chiropractic Services
If you require Emergency Chiropractic Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Chiropractic Services are Covered Benefits provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain, such that a person could reasonably expect that a delay of immediate Chiropractic Services could result in serious jeopardy to your health or body functions or organs. See also the "Definitions" section of this *Evidence of Coverage*, for "Emergency Chiropractic Services."

ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's Independent Medical Review process.

You may receive Emergency Chiropractic Services from any chiropractor. ASH Plans will not cover any services as Emergency Chiropractic Services unless the chiropractor rendering the services can show that the services in fact were Emergency Chiropractic

Services. You must receive all other covered Chiropractic Services from a chiropractor under contract with ASH Plans ("Contracted Chiropractor") or from a non-Contracted Chiropractor only upon a referral by ASH Plans.

Because ASH Plans arranges Chiropractic Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling "**911**". You are encouraged to use appropriately the "**911**" emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

Acupuncture Services

If you require Emergency Acupuncture Services, American Specialty Health Plans of California, Inc. (ASH Plans) will provide coverage for those services. Emergency Acupuncture Services are covered Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system, or causing Pain, or Nausea which manifests itself by acute symptoms of sufficient severity that a person could reasonably expect that a delay of immediate Acupuncture Services could result in serious jeopardy to your health or body functions or organs. See also the "Definitions" section of this *Evidence of Coverage*, for "Emergency Acupuncture Services."

ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's Independent Medical Review process.

You may receive Emergency Acupuncture Services from any acupuncturist. ASH Plans will not cover any services as Emergency Acupuncture Services unless the acupuncturist rendering the services can show that the services in fact were Emergency Acupuncture Services. You must receive all other covered Acupuncture Services from an acupuncturist under contract with ASH Plans ("Contracted Acupuncturist") or from a non-Contracted Acupuncturist only upon a referral by ASH Plans.

Because ASH Plans arranges only Acupuncture Services, if you require medical services in an emergency, ASH Plans recommends that you consider contacting your Primary Care Physician or another Physician or calling "**911**". You are encouraged to use appropriately the "**911**" emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition that requires an emergency response.

SCHEDULE OF BENEFITS AND COPAYMENTS

Copayments, benefits and certain legal remedies (as shown in the "General Provisions" section) available to Members who obtain care in Mexico through SIMNSA may differ from those available to Members who obtain care in California through the Salud Network.

All care except for Emergency Services and Care and Urgently Needed Care must be performed by your Physician Group or SIMNSA, or authorized by them to be performed by another Health Care Provider.

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

There are two levels of Copayments listed for each Covered Benefit. The Health Net Salud Network (Salud Network) Copayment will apply when to you receive care through your Salud Network Physician Group. The SIMNSA Copayment will apply when you receive care in Mexico through SIMNSA.

Please note: Members who live in California may receive Covered Benefits in either California from their Salud Network Physician Group or in Mexico from a SIMNSA Provider.

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.

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

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

	SIMNSA	Salud Network
Use of emergency room (facility and professional services)	$15	$50
Use of urgent care center (facility and professional services)	$15	$15

Copayment Exceptions:

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

For Emergency Services and Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this Plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

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

	SIMNSA	Salud Network
Use of emergency room (facility and professional services)	$15	$50
Use of urgent care center (facility and professional services)	$15	$15

Copayment Exceptions:

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

For Emergency Services and Care in an emergency room or urgent care center, you are required to pay only the Copayment amounts required under this plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

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

	SIMNSA	Salud Network
Ground ambulance	$0	$0
Air ambulance	Not covered	$0

Note:

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

Ambulance Services (Mental Health or Substance Use Disorders)

	SIMNSA	Salud Network
Ground ambulance	$0	$0
Air ambulance	Not covered	$0

Note:

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

Office Visits

	SIMNSA	Salud Network
Visit to Physician, Physician Assistant, or Nurse Practitioner at contracting Physician Group	$15	$15
Specialist or specialty care consultation	$15	$15
Visit to CVS MinuteClinic*	Not covered	$15
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	Not covered	$15
Vision examinations including refractive eye exams by an ophthalmologist	$0	$0
Vision examinations including refractive eye exams by all other providers	$0	$0
Hearing examinations for hearing loss by an otolaryngologist	$0	$0
Hearing examinations for hearing loss by all other providers	$0	$0
Telehealth consultation through the Select Telehealth Services Provider**	Not covered	$0

Notes:

Self-referrals are allowed for obstetrician, 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.)

* Specialist referrals following care from CVS MinuteClinic must be obtained through the contracting Physician Group. Preventive Care Services through the CVS MinuteClinic are subject to the Copayment shown below under "Preventive Care Services."

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

Preventive Care Services

	SIMNSA	Salud Network
Preventive Care Services	$0	$0

Notes:

Covered Benefits include, but are not limited to, annual preventive physical examinations, immunizations, 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 Benefits 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.

The Outpatient Prescription Drug Program is provided by CVS Caremark. Coverage of preventive drugs and FDA approved women's contraceptive drugs are included in CVS Caremark coverage with no cost sharing. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet, or call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details of prescription drug, preventive drug and women's contraceptive drug coverage.

Through the SIMNSA tier the Prescribed preventive drugs including Smoking Cessation drugs and women's contraceptives are covered at no cost to the Member. Such drugs or devices must be prescribed by a Physician from your selected Physician Group, an authorized referral Specialist or an emergent or urgent care Physician and dispensed through SIMNSA pharmacy.

Covered preventive drugs are over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Women's contraceptives available through the SIMNSA pharmacy includes vaginal, oral, transdermal and emergency contraceptives. 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 SIMNSA pharmacy if not required in conjunction with Emergency Services and Care as defined. Refer to the "Family Planning and Infertility Services" under "Covered Services and Supplies," section, for information about additional contraceptives that are covered under this Plan.

Over-the-counter preventive drugs and women's contraceptives that are covered under this Plan require a prescription from your SIMNSA Physician. You must present the prescription at a SIMNSA pharmacy to obtain such drugs or contraceptives.

This Plan does not cover Brand Name Drugs that have generic equivalents. However, if a brand name drug is Medically Necessary and the Physician obtains pre-approval from SIMNSA, then the brand name drug will be dispensed at no charge.

Hospital Visits by Physician

	SIMNSA	Salud Network
Physician visit to Hospital or Skilled Nursing Facility	$0	$0

Allergy, Immunizations and Injections

	SIMNSA	Salud Network
Allergy testing	$0	$0
Allergy injection services	$0	$0
Allergy serum	$0	$0
Immunizations for foreign travel	Not covered	$0
Immunizations for occupational purposes	Not covered	$0
Injections		
Office based injectable medications - administration (per dose)	$0	$0
Office based injectable medications - injected substance (per dose)	$0	$0
Self-injectable drugs	$5	See note below*

Notes:

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

*Under the Salud Network, certain injectable drugs which are considered self-administered are not covered under the medical benefits even if they are administered in a Physician's office. Injectable drugs which are considered self-administered are covered under the pharmacy benefit. The Outpatient Prescription Drug Program is provided by CVS Caremark. Please call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details.

Rehabilitation and Habilitation Therapy

	SIMNSA	Salud Network
Physical therapy	$5	$15
Occupational therapy	$5	$15
Speech therapy	$5	$15
Pulmonary rehabilitation therapy	$5	$15
Cardiac rehabilitation therapy	$5	$15
Habilitative therapy	$5	$15

Notes:

These services will be covered when Medically Necessary.

Rehabilitation and habilitation therapy performed in an inpatient setting is covered in full when Medically Necessary. For further details please look under the heading "Inpatient Hospital Confinement" of "Covered Services and Supplies" section.

Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain limitations as described under the heading "Therapies" in the "Exclusions and Limitations" section.

Care for Conditions of Pregnancy

	SIMNSA	Salud Network
Prenatal or postnatal office visit	$0	$0
Specialist consultation regarding pregnancy	$15	$15
Newborn care office visit (birth through 30 days) for well-baby	$0	$0

Physician visit to the mother or newborn at a Hospital	$0	$0
Normal delivery, including cesarean section	$0	$0
Circumcision of newborn (birth through 30 days)*	$0	$0

Notes:

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "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 is covered in full.

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

Termination of pregnancy and related services are covered in full. For services being rendered in Mexico, terminations of pregnancy are covered to the extent permitted by Mexican law. 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

	SIMNSA	Salud Network
Sterilization of female	$0	$0
Sterilization of male	$0	$0
Abortion*	$0	$0

Notes:

Contraceptive services: Voluntary family planning services includes surgical procedures for sterilization, diaphragms, and coverage for a variety of other federal Food and Drug Administration approved contraceptive devices. Subject to Health Care Reform.

Abortion is covered for all pregnant Members including, but not limited to, transgender individuals.

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

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

*For services being rendered in Mexico, terminations of pregnancy are covered to the extent permitted by Mexican law.

Infertility Services

	SIMNSA	Salud Network
Infertility services (all Covered Benefits that diagnose, evaluate or treat Infertility)	50%	50%

Notes:

Infertility services include professional services, inpatient and outpatient care, ancillary services, medications administered to diagnose and treat the infertility, and treatment by injections.

Infertility services (which include GIFT) and all Covered Benefits that prepare the Member to receive this procedure, are covered only for the Health Net Member.

Effective July 1, 2027, Infertility services (which include GIFT, IVF and ZIFT, limited to 3 completed oocyte retrievals per lifetime) with unlimited embryo transfers in accordance with guidelines of the American Society for Reproductive Medicine (ASRM) and the terms of this *Evidence of Coverage.* Covered Benefits that prepare the Member to receive these procedures, are covered only for the Health Net Member. The applicable Copayment requirements apply to any services and supplies required for Infertility services. Bundled treatments require a Copayment of $15. Treatment bundles may include Medically Necessary tests, services, and medication.

Refer to the "Infertility Services" and "Fertility Preservation" provisions in the "Covered Services and Supplies" section for additional information.

Other Professional Services

	SIMNSA	Salud Network
Surgery		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Assistance at surgery		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Administration of anesthetics		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Chemotherapy	$0	$0
Radiation therapy		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Laboratory services		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Diagnostic imaging (including x-ray) services		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Medical social services	$0	$0
Patient education*	$0	$0
Nuclear medicine (use of radioactive materials)		
In an inpatient setting	$0	$0
In a Physician's office or outpatient facility	$0	$0
Renal dialysis	$0	$0

Organ, tissue, or stem cell transplants	$0	See note below**
Infusion therapy***		
In home	Not covered	$0
In an office or outpatient setting	$0	$0

Notes:

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 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 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.

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

Medical Supplies

	SIMNSA	Salud Network
Durable Medical Equipment, nebulizers, including face masks and tubing*	$0	$0
Orthotics (such as bracing, supports and casts)	$0	$0
Corrective Footwear (for the treatment of conditions not related to diabetes)**	$0	$0
Diabetic equipment**	$0	$0
Corrective Footwear (for the treatment of conditions related to diabetes)	Not covered	$0
Prostheses (internal or external)****	$0	$0
Blood or blood products except for drugs used to treat hemophilia, including blood factors	$0	$0
Drugs used to treat hemophilia, including blood factors*****	$0	See note below
Hearing aids***	Not covered	$0

Notes:

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

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

* For coverage information, please see "Durable Medical Equipment" in the "Covered Services and Supplies" section.

** For a list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in the "Covered Services and Supplies" section.

*** Hearing aids are covered to a maximum payment of $1000 every 36 months per Member. Hearing aids are covered at 100% in both ears every 36 months when Medically Necessary to prevent and treat speech and language development delay due to hearing loss. Coverage includes repair and maintenance of the hearing aid at no additional charge. The initial hearing exam and

fitting are also subject to the hearing examination Copayment. Look under "Office Visits" heading in this "Schedule of Benefits and Copayments" section, to determine any additional Copayment that may apply. Additional charges for batteries (including the first set) or other equipment related to the hearing aid, or replacement of the hearing aid are not covered.

**** Prostheses include coverage for Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank (Salud Network only). Prostheses also include of ostomy and urological supplies. See "Ostomy and Urological Supplies" portion of the "Covered Services and Supplies" section.

***** Under the Salud Network, drugs for the treatment of hemophilia (including blood factors) are not covered under the medical benefits even if they are administered in a Physician's office. These drugs which are self-administered are covered under the pharmacy benefit. The Outpatient Prescription Drug Program is provided by CVS Caremark. Please call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details.

Home Health Care Services

	SIMNSA	Salud Network
Home health visits	Not covered	$0

Note:

Home Health Care Services for Physical, Occupational, and Speech Therapy require a $15 copay.

Hospice Services

	SIMNSA	Salud Network
Hospice care	See note below	$0

Note:

Hospice care services are available in Mexico only in an acute Hospital setting to the extent available and under the provision mentioned in the "Exclusions and Limitations" section. Your Copayment for Hospice services provided by SIMNSA will be the same as the Copayment shown under "Inpatient Hospital Services."

Inpatient Hospital Services

	SIMNSA	Salud Network
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$0	$0

Note:

Inpatient care for Infertility is described above in the "Infertility Services" section.

Outpatient Facility Services

	SIMNSA	Salud Network
Outpatient facility services (other than surgery)	$0	$0
Outpatient surgery (surgery performed in an Outpatient Surgical Center only)	$0	$0
Outpatient surgery (surgery performed in an Outpatient Hospital setting)	$0	$0

Notes:

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, neuromuscular rehabilitation and other professional services to determine any additional Copayments that may apply.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an Outpatient facility require the Copayment applicable for Outpatient facility services.

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

Skilled Nursing Facility Services

	SIMNSA	Salud Network
Room and board in a semi-private room with ancillary (additional) services	$0	$0

Limitation:

Skilled Nursing Facility services are covered for up to a combined maximum of 100 days a Calendar Year for each Member under the SIMNSA and Salud Network tiers. This benefit is provided for Members residing in Mexico in a Hospital Skilled Nursing Facility Unit.

Outpatient Prescription Drug Benefits in the United States

The Outpatient Prescription Drug Program is provided by CVS Caremark. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet, or call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details of prescription drug, preventive drug and women's contraceptive drug coverage.

Outpatient Prescription Drug Benefits in Mexico (by SIMNSA)

SIMNSA Participating Pharmacies (up to a 30 day supply in Mexico)

	SIMNSA
Prescription Drugs dispensed through a SIMNSA Participating Pharmacy	$5
Lancets	$0
Oral Infertility drugs*	50%
Preventive drugs and women's contraceptives	$0

Note:

* Only services that diagnose Infertility are covered under the SIMNSA tier of your Plan. All other infertility services are not covered under the SIMNSA tier of your Plan.

Preventive Drugs and Women's Contraceptives:
Preventive drugs including smoking cessation drugs, and contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member through the SIMNSA tier. Please see the "Preventive Care Services," information portion within this "Schedule of Benefits and Copayments" section.

Chiropractic Services and Supplies

Chiropractic services and supplies are provided by Health Net. Health Net contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you may obtain chiropractic care by selecting a Contracted Chiropractor from our ASH Plans Contracted Chiropractor Directory.

Office Visits	***Copayment***
New patient examination	$15
Each subsequent visit	$15
Re-examination visit	$15

Second opinion $15

Note:

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

Limitations:

Up to 20 office visits to a Contracted Chiropractor during a Calendar Year are covered (combined with office visits to the Contracted Acupuncturist).

A visit to a Contracted Chiropractor to obtain a second opinion generally will not count toward the Calendar Year visit limit if you were referred by another Contracted Chiropractor. However, the visit to the first Contracted Chiropractor will count toward the Calendar Year visit limit.

Diagnostic Services	***Copayment***
X-rays	$0
Laboratory test	$0
Chiropractic Appliances	Copayment
For each appliance	$0

Limitation:

Up to a maximum of $50 is covered for each Member during a Calendar Year for covered Chiropractic Appliances.

Acupuncture Services

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

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

Note:

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

Limitations:

Up to 20 office visits to a Contracted Acupuncturist during a Calendar Year are covered (combined with office visits to the Contracted Chiropractor).

A visit to a Contracted Acupuncturist to obtain a second opinion generally will not count toward the Calendar Year visit limit if you were referred by another Contracted Acupuncturist. However, the visit to the first Contracted Acupuncturist will count toward the Calendar Year visit limit.

Mental Health or Substance Use Disorder Benefits

In Mexico, the Mental Health or Substance Use Disorder benefits are administered by SIMNSA. In California, the Mental Health or Substance Use Disorder benefits are administered by Health Net.

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES THROUGH SIMNSA

Mental Health	**SIMNSA**
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management, drug therapy monitoring)	$15

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***) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by SIMNSA) ..... Not covered

Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Substance Use Disorders **SIMNSA**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) $15

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, and other outpatient services including, but not limited to, laboratory services or rehabilitation when provided for a Mental Health or Substance Use Disorder condition***) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by SIMNSA) ..... Not covered

Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Detoxification $0

MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES THROUGH HEALTH NET

Mental Health **Health Net**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)* $15

Outpatient group therapy session $7.50

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, and 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***) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) $15
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0

Substance Use Disorders **Health Net**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)* $15
Outpatient group therapy session $7.50
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), and other outpatient services including, but not limited to, laboratory services or rehabilitation when provided for a Mental Health or Substance Use Disorder condition***) $0
Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) $15
Participating Mental Health Professional visit to Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0
Inpatient services at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center $0
Detoxification at a Hospital, Participating Behavioral Health Facility or Residential Treatment Center on inpatient basis $0

Exception:

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

***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.

Note:

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

OUT-OF-POCKET MAXIMUM

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

Once the total amount of all Copayments you pay for Salud Network and SIMNSA Covered Benefits under this *Evidence of Coverage* including Acupuncture Services provided by American Specialty Health Plans of California, Inc. (ASH Plans) in any one Calendar Year equals the Out-of-Pocket Maximum amount, no Copayment for Covered Benefits may be imposed on any Member, except as described in "Exceptions to the OOPM" below.

The OOPM amounts for this Plan are:

One Member	$1500
Two Members	$3000
Family (three or more Members)	$3000

Any Copayment or coinsurance paid for Covered Benefits received from a Salud Network provider will also apply toward the OOPM for SIMNSA Providers. Any coinsurance paid for Covered Benefits received from a SIMNSA Provider will also apply toward the OOPM for Salud Network providers.

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

The following Copayments and expenses paid by you for Covered Benefits under this Plan will not be applied to the OOPM amount:

- Services from a CVS MinuteClinic that are not otherwise covered under this Plan. Please refer to “Covered Services and Supplies” Section for additional information.
- Chiropractic Services provided by ASH Plans.
- You are required to continue to pay these Copayments listed in the bullets above after the OOPM has been reached.

How the OOPM Works
Keep a record of your payment for Covered Benefits.

You will be notified by us of your OOPM accumulation for each month in which benefits were used. You will also be notified when you have reached your OOPM amount for the Calendar Year. You can also obtain an update on your OOPM accumulation by calling the Customer Contact Center at the telephone number on your ID card.

- If an individual Member pays amounts for Covered Benefits in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for Covered Benefits paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.

- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for Covered Benefits 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.

Please keep a copy of all receipts and canceled checks for payments for Covered Benefits as proof of Copayments made.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

The Covered Benefits of this Plan are available to the Subscribers and Dependents who live or work in the Health Net Salud Service Area and meet any additional eligibility requirements of the Group.

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS "Health Program Guide" for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

Or call:
888 CalPERS (or 888-225-7377)
(916) 795-3240 (TDD)

The Covered Benefits of this Plan are available to the individuals who live or work in the Health Net Salud Service Area for California residents and the SIMNSA Service area for Mexico residents (as respectively defined in the "Definitions" section) and meet any additional eligibility requirements of the Group.

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS Employer and are no longer working for any Employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled Dependents must reside in the health plan's service area. When you use your work ZIP Code, all enrolled Dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

In Hospital on Your Effective Date

Please refer to the CalPERS informational booklet "Health Program Guide" for details concerning hospitalization at the time of enrollment.

Totally Disabled on Your Effective Date

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

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

No extension will be granted unless Health Net receives written certification of such total disability from the Member's Physician Group within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Health Net.

Late Enrollment Rule

Please refer to the CalPERS informational booklet "Health Program Guide" for details concerning late enrollment rules.

Special Enrollment Rule for Newly Acquired Dependents

Please refer to the CalPERS informational booklet "Health Program Guide" for details concerning new Dependents due to childbirth, adoption or marriage rules.

Note:
Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you should contact CalPERS Customer Account Services Division - Health Account Services and Health Net to add your child to your coverage.

Special Reinstatement Rule for Reservists Returning From Active Duty

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

Special Reinstatement Rule under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan physician.

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of the "Introduction to Health Net" section, Members residing in California must select a contracting Physician Group close enough to their residence or place of work to allow reasonable access to care. Please call Health Net Customer Contact Center if you have questions involving reasonable access to care. Members accessing care in Mexico may go to any Primary Care Physician in the SIMNSA Network and will not be limited to selecting a contracting Physician Group for services.

Note:
Enrollment in this Plan is limited to Physician Groups in the Salud Network in California and SIMNSA in Mexico.

For coverage under this policy to continue, the Subscriber must work or live in the Health Net Salud Service Area in California at all times.

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

- The Group's Open Enrollment Period occurs;
- The Member moves to a new address (notify Health Net within 30 days of the change);
- The Member's employment work-site changes (notify Health Net within 30 days of the change);
- Determined necessary by Health Net; or
- The Member exercises the once-a-month transfer option.

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

number on your Health Net ID card for prompt review of your request.

Effective Date of Transfer

Once your request for a transfer is received, 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 hospitalization and you still wish to transfer after the medical condition or treatment for it has ended, please call Health Net's Customer Contact Center or SIMNSA 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 contracting 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 "How to Enroll for Coverage" provision earlier in this section.)

Any Member receiving care in Mexico may go to any Primary Care Physician in the SIMNSA Provider Directory at any time without sending in a request.

When Coverage Ends

You must notify the Group of changes that will affect your eligibility. The Group will send the appropriate request to Health Net according to current procedures. Health Net is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

All Group Members

All Members of a Group become ineligible for coverage under this Plan at the same time if the Group Service Agreement (between the Group and Health Net) is terminated, including for termination due to nonpayment of subscription charges by the Group, as described below in the "Termination for Nonpayment of Subscription Charges" provision.

Termination for Nonpayment of Subscription Charges

If the Group fails to pay the required subscription charges when due, the Group Service Agreement could be canceled after a 30-day grace period.

When subscription charges are not paid by the due date, a Late Payment Notice is generated. The date of the Late Payment Notice is the first day of the 30-day grace period. The Notice will include the dollar amount due to Health Net, the last day of paid coverage, and the start and last day of the grace period, after which coverage will be canceled if subscription charges are not paid. Coverage will continue during the grace period but the member is responsible for unpaid subscription charges and any required Copayments, coinsurance or Deductible amounts.

If Health Net does not receive payment of the delinquent subscription charges from your employer within the 30-day grace period, Health Net will mail a termination notice that will provide the following information: (a) that the Group Service Agreement has been canceled for nonpayment of subscription charges; (b) the specific date and time when coverage is terminated for the Subscribers and all dependents; and (c) your right to submit a grievance.

If coverage through this Plan ends for reasons other than nonpayment of subscription charges, see the "Coverage Options Following Termination" section below for coverage options.

Termination for Loss of Eligibility

In addition to no longer residing in the Health Net Salud Service Area for California residents and the SIMNSA Service area for Mexico residents, individual Members become ineligible on the date any of the following occurs:

- The Member no longer meets the eligibility requirements established as specified in the CalPERS "Health Program Guide".

This will include a child subject to a medical child support order, according to state or federal law, who becomes ineligible on the earlier of:

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

- The Member establishes primary residency outside the United States, and does not work within the Health Net Salud Service Area.
- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- The Subscriber's marriage or domestic partnership ends by divorce, annulment, or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse (now former spouse) and that spouse's enrolled Dependents, who were related to the Subscriber only because of the marriage, will end.

When the Member ceases to reside in the Service Area, coverage will be terminated effective on midnight of the last day of the month in which loss of eligibility occurred. However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area, does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Services and Care or Urgently Needed Care.

Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by Health Net.

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

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

Termination for Cause

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

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

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

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

How to Appeal Your Termination

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

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

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "Grievance Procedures" provision in the "General Provisions," section. If your complaint is decided in your favor, Health Net will reinstate your coverage back to the date of the termination.

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

Coverage Options Following Termination

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

COBRA Continuation Coverage: Many groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible Dependents, even if they live outside California. Please check with your Group to determine if you and your covered Dependents are eligible.

Cal-COBRA Continuation Coverage: If you have exhausted COBRA and you live in the Health Net service area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this *Evidence of Coverage* (EOC) through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

Health Net Will Offer Cal-COBRA to Members: Health Net will send Members whose federal COBRA coverage is ending information on Cal-COBRA rights and obligations along with the necessary premium

information, enrollment forms, and instructions to formally choose Cal-COBRA Continuation Coverage. This information will be sent with the notice by U.S. mail of pending termination of federal COBRA.

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

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

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

The Member must submit the first payment within 45 days of delivering the completed enrollment form to Health Net in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Member's first payment must be delivered to Health Net by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to Health Net, the Member's Cal-COBRA election is not effective and no coverage is provided.

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

Employer Replaces Previous Plan:

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

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

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

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

When Does Cal-COBRA Continuation Coverage End?

When a Qualified Beneficiary has chosen Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

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

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

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

- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), Employers are required to provide employees who are absent from employment to serve in the uniformed services and their Dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your Group to determine if you are eligible.
- **Extension of Benefits:** Described below in the subsection titled "Extension of Benefits."

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if you lose your Health Net coverage because the Group Service Agreement is discontinued, and you are ***totally disabled*** at that time.

When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in the "Schedule of Benefits and Copayments" section will continue to apply.

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

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

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

- For the Subscriber it means that because of an illness or injury, the Subscriber is

unable to engage in employment or occupation for which they are or become qualified by reason of education, training, or experience; furthermore, the Subscriber must not be employed for wage or profit.

- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of their age and family status.

How to Obtain an Extension

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. No extension will be granted unless Health Net receives written certification of such total disability from the Member's Physician Group within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Health Net.

When the Extension Ends

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

- On the date the Member is no longer totally disabled;
- On the date the Member becomes covered by a replacement health policy or plan obtained by the Group and this coverage has no limitation for the disabling condition;
- On the date that available benefits are exhausted; or
- On the last day of the 12-month period following the date the extension began.

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 or SIMNSA 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 Physician Group within the Salud Network, SIMNSA or authorized by them the Physician Group or SIMNSA (medical), or Health Net or SIMNSA (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 Benefits may require a Copayment 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

Ambulance Services

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

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 services are covered when Medically Necessary and when your condition requires the use of services that only a licensed ambulance can provide when the use of other means of transportation would

endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

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

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 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, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Member and for the prior approved bariatric weight loss surgery. All requests for travel expense reimbursement must be prior approved by Health Net.

Approved travel-related expenses will be reimbursed as follows:

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

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

- Expenses for tobacco, alcohol, telephone, television 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.

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.

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.

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

Approved Clinical Trials
Routine patient care costs for items and services furnished in connection with participating in an Approved Clinical Trial are covered when Medically Necessary, authorized by Health Net, and either the Member's treating Physician has recommended participation in the trial or the Member has provided medical and scientific information establishing eligibility for the clinical trial. Approved Clinical Trial services performed by nonparticipating providers are covered only when the protocol for the trial is not available through a participating provider. 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 standard provisions of Health Net, including drugs, items, devices and services that would normally be covered under this *Evidence of Coverage*, if they were not provided in connection with an Approved Clinical Trial 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 this "Covered Services and Supplies" section for additional information.

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

Clinical trials are not available in Mexico.

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 "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 *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.

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.

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 or Participating Mental Health Professional are subject to the applicable Deductible and Copayment shown in the "Prescription Drugs" provision of the "Schedule of Benefits and Copayments" section.

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

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

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

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including those listed below. The applicable diabetic equipment Copayment will apply, as shown in "Schedule of Benefits and Copayments," Section.

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Blood glucose monitors (including those designed to assist the visually impaired)
- Ketone urine testing strips
- Lancet puncture devices

Additionally, the following supplies are covered under the medical benefits 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).

- 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.

Your group has contracted with CVS Caremark for your pharmacy benefits. The following items would be covered through your CVS Caremark Pharmacy benefits.

- Blood glucose monitoring testing strips
- Lancets
- Pen needles
- Insulin syringes and needles
- Insulins
- Glucagon

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.

Durable Medical Equipment

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

Equipment and medical supplies required for home hemodialysis and home peritoneal dialysis are covered after you receive appropriate training at a dialysis facility approved by Health Net. Coverage is limited to

the standard item of equipment or supplies that adequately meets your medical needs.

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

Corrective Footwear for the management and treatment of diabetes-related medical 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 or SIMNSA, will decide whether to repair or replace an item. In assessing medical necessity for Durable Medical Equipment coverage, Health Net applies nationally recognized Durable Medical Equipment 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).

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.

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

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

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 this "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.

Family Planning

These family planning benefits are available to Members regardless of sex, sexual orientation, or gender identity.

This Plan covers counseling and planning for contraception, fitting examinations for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines are covered as Preventive Care Services.

IUDs, implantable and injectable contraceptives are covered in Mexico through SIMNSA. Prescribed contraceptives are also covered, as shown under "Preventive Care Services" in the "Schedule of Benefits and Copayments" section.

IUDs, implantable and injectable contraceptives are covered as a medical benefits in the United States. Prescribed contraceptives are covered by CVS Caremark. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet, or call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details of prescription drug, preventive drug and contraceptive drug coverage.

Infertility Services

Medically Necessary Infertility services are covered when a Member and/or the Member's partner is infertile (refer to Infertility in the "Definitions" section). If one partner does not have Health Net coverage, Infertility services are covered only for the Health Net Member.

Infertility services include:

- Office visits, laboratory services, professional services, inpatient and outpatient services;
- Treatment by injections;
- Artificial insemination;
- Gamete intrafallopian transfer (GIFT); and
- Related processes or supplies that are Medically Necessary to prepare the Member to receive the covered infertility treatment.

Infertility services do not include:

- In-vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT;
- Procedures that involve harvesting, transplanting or manipulating a human ovum when provided in connection with Infertility treatments that are not covered by this Plan. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these procedures.
- Collection or storage of gamete or embryo unless Medically Necessary

to prepare the member to receive the covered Infertility treatment;

- Purchase of sperm or ova;
- Injections for Infertility when provided in connection with services that are not covered by this Plan.

Infertility services are subject to the Copayments and benefit limitations, as shown in the "Schedule of Benefits and Copayments" section.

Treatment of Infertility and fertility services are covered without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

Effective July 1, 2027, Infertility services include:

- In-vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT); and
- Oocyte retrieval and embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

Infertility services do not include:

- Oocyte retrievals after the lifetime maximum of 3 completed oocyte retrieval cycles has been met.

Fertility Preservation

This Plan covers Medically Necessary services and supplies for Standard Fertility Preservation Services for Iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused directly or indirectly by surgery, chemotherapy, radiation or other medical treatment. Standard Fertility Preservation Services are procedures consistent with the established medical treatment practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

This benefit is subject to the applicable Copayments shown in "Schedule of Benefits and Copayments" section, as would be required for Covered Benefits to treat any illness or condition under this Plan.

Covered cryopreservation services include the freezing and storage of:

- Sperm
- Oocyte
- Embryo

Coverage for fertility preservation does not include the following:

- Follow-up Assisted Reproductive Technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization, and/or embryo transfer.
- Pre-implantation genetic diagnosis.
- Donor eggs, sperm or embryos.
- Gestational carriers (surrogates).

Effective July 1, 2027, this Plan covers Medically Necessary services and supplies for Standard Fertility Preservation Services for Infertility unrelated to Iatrogenic cause.

Cryopreservation is limited to a maximum of five (5) years from the date the genetic material is initially cryopreserved. Separate coverage limits and storage periods may apply to cryopreservation services provided for Iatrogenic Infertility.

Surrogate Pregnancy (Effective July 1, 2027)

When a Member utilizes a gestational carrier or surrogate, embryo transfer to the gestational carrier or surrogate will be treated in the same as an embryo transfer to the Member for purposes of administering the benefit limit of three (3) completed oocyte retrievals, including three (3) attempts to collect or retrieve sperm, and will not reduce, limit, or otherwise adversely affect coverage eligibility:

Services do not include:

- Reversal of voluntary sterilization.
- Compensation, agency fees, matching fees, or other non-medical expenses associated with a surrogate or gestational carrier arrangement or adoption.
- Legal services related to adoption, surrogacy agreements or parental proceedings.
- Storage fees for cryopreservation incurred after the applicable covered storage period has expired.
- Cryopreservation, storage, or fertility preservation services that are not Medically Necessary or that exceed the applicable benefit limitations.
- Replacement, relocation, or transportation of cryopreserved materials between facilities, unless authorized by the Plan.
- Experimental or investigational, preservation techniques for cryopreserved materials.

Preventive Care Services

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

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

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

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

benefits/. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA) recommended cancer screenings, including cervical cancer screening (including human papillomavirus (HPV) screening), 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 healthfully, treating depression, prevention of sexually transmitted diseases, and reducing alcohol use
- Routine immunizations to prevent diseases and infections as recommended by the ACIP (e.g., chickenpox, measles, polio, meningitis, mumps, flu, pneumonia, shingles, or HPV
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Anxiety screening for children, adolescents, and adults
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes (diabetes in pregnancy); sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies

and counseling; and 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 phone number on your Health Net ID card or visiting our website at www.healthnet.com/calpers.

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

Preventive Care Services, provided by Health Net, and FDA approved women's contraceptive, provided by CVS Caremark, are covered at no cost to You. Please refer to your CVS Caremark Prescription Drug Program Evidence of Coverage booklet, or call CVS Caremark Customer Care at 1-833-291-3649 (TTY: 711) for complete details of prescription drug, preventive drug and women's contraceptive drug coverage.

Hearing Aids
Standard hearing devices (analog or digital), which typically fit in or behind the outer ear, used to restore adequate hearing to the Member and determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to "Schedule of Benefits and Copayments," Section.

Home Health Care Services
The services of a Home Health Care Agency in the Member's home are covered for Members residing in California 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. Private Duty Nursing (or shift care, including any portion of shift care services) is not a Covered Benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substance 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 (substance 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 substance 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 drugs or other covered substances used in infusion therapy.

Covered supplies include injectable Prescription Drugs or other substance which are approved by the California Department of Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substance 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 substance obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA approved drugs or medication 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.

Home Visit
Through the Salud Network, 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.

Home visits are not covered through SIMNSA.

Hospice Care
Hospice care in an Outpatient setting and in a Hospice facility is a Covered Benefits for Members residing in California. Hospice care is available in Mexico only in an acute Hospital setting.

Hospice care is available for Members diagnosed as terminally ill by a Member 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.

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 are covered for the Medically Necessary treatment of medical conditions when prescribed by the Member's Primary Care Physician and authorized by Health Net.

You will be charged for the appropriate Copayment shown in the "Schedule of Benefits and Copayments" section. Distribution of drugs, needles and syringes through the specialty Pharmacy vendor are only available in the United States.

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 Emergency Services and Care or Urgently Needed Care as defined in the “Definitions” section.

Genetic Testing and Diagnostic Procedures
Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Biomarker testing is covered when determined by Health Net to be Medically Necessary, including for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. However, Prior Authorization is not required for biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer.

Genetic testing will not be covered for nonmedical reasons or when a Member has no medical indication. For information regarding genetic testing and diagnostic procedures of a fetus, see the "Pregnancy" portion of this "Covered Services and Supplies" section.

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

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral
If you are a female Member you may obtain OB/GYN Physician services without first contacting your Salud Network or SIMNSA 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 that provides such services.

If such services are not available in your Physician Group, you may go to one of the Physician Group's referral Physicians (or one of SIMNSA's referral Physicians, if applicable) 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 or attending 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, contact the Customer Contact Center at the phone number on your Health Net ID card or visit our website at www.healthnet.com/calpers.

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.

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

Health Net and SIMNSA have specific 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 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 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.

Members are solely responsible for any U.S. Immigration and Naturalization Service documentation or authorization to enter the United States. Health Net is not responsible to assure access to Covered Benefits from its participating providers in the United States where the Member is not permitted to enter the United States to obtain such services because they have not obtained the necessary documentation or authorization from the U.S. Immigration and Naturalization Service. Enrollees without such documentation and authorization will be required to receive all Covered Benefits through SIMNSA participating providers in Mexico.

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:

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

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

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

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than Copayments for professional or Outpatient Hospital facility services. Please refer to "Outpatient Facility Services" in 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 Emergency Services and Care or Urgently Needed Care as defined in the "Definitions" section.

Patient Education
Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs, and asthma management programs are covered. Your Physician Group will coordinate access to these services. Health Net will pay for a diabetes instruction program supervised by a licensed or registered health care professional. A diabetes instruction program is a program designed to teach you (the diabetic) and your covered dependent about the disease process, medical nutrition therapy and the daily management of diabetic 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 (or under Mexico law for services

provided in Mexico). 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.

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

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

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

Vitamins and Nutritional Supplements
Prescription vitamins and nutritional supplements are covered. Other specialized formulas and nutritional supplements, including vitamins and herbal remedies, are not covered.

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

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

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. For more information, you can call the Customer Contact Center telephone number listed on your Health Net ID card or visit our website at www.healthnet.com/calpers. For services being rendered in Mexico, terminations of pregnancy are covered to the extent permitted by Mexican law.

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.

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

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

Donor human milk is an alternative to breastfeeding or formula for infants and is of particular benefit to pre-term infants. Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank is covered through the Salud Network. See "Prostheses" in the "Schedule of Benefits and Copayments" section for Copayment requirements.

Doula Program
Health Net offers a doula program for Members who are pregnant or were pregnant in the past year. Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support for miscarriage, stillbirth, and termination of pregnancy.

Doula visits may be provided virtually or in person with locations in any setting including, but not limited to homes, office visits, hospitals, or alternative birth centers; however, the actual labor and delivery must occur in a hospital or birthing center.

For more information, you can call the Customer Contact Center telephone number listed on your Health Net ID card or visit our website at www.healthnet.com/calpers.

What does the Doula program offer?
Doula visits include:

- One extended initial visit (90 minutes).
- Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in stillbirth), miscarriage, and abortion.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

Limitations:

- All visits are limited to one per day, per Member, however, one prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support.
- The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.

This Doula program does not offer the following:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Prostheses
Internal and external prostheses required to replace a body part are covered. Also covered are internally implanted. Examples are artificial legs surgically implanted hip joints, 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 spacers for the treatment of asthma and 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.

For Members residing in California, Health Net or the Member's Physician Group will select the provider or vendor for the items. In Mexico, SIMNSA will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, Health Net, SIMNSA or the Physician Group will determine which device or appliance will be covered. SIMNSA will provide the same or as closely similar devices as those that are approved by the Food and Drug Administration for general use.

Prostheses will be replaced when no longer functional. However, repair or replacement for loss or misuse is not covered. Health Net, SIMNSA or the Physician Groups participating in the Salud Network, 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.

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.

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

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 "Dental Services" and "Disorders of the Jaw" portions of this "Covered Services and Supplies" section. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

Then, the following are covered:

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to remove or reduce skin or tissue; or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

Health Net 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. Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

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

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

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contract-ed Physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of their license, to treat physical conditions and Mental Health or Substance Use Disorders, or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the Plan or the Member's Physician Group. The services must be based on a treatment plan authorized, as required by the Plan or the Member's Physician Group. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See the "General Provisions" section for the procedure to request Inde-pendent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

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

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

This Plan covers massage therapy only when such services are part of a physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by Health Net or your Physician Group.

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 *Evidence of Coverage*.

Renal Dialysis
If you reside in California, 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 unless provided by a SIMNSA Provider in Mexico.

In Mexico, Outpatient renal dialysis services are covered when provided by a SIMNSA provider.

Routine Foot Care
Routine foot care including callus treatment, corn paring or excision, toenail trimming, massage of any type and treatment for fallen arches, flat or pronated feet are covered only when Medically Necessary for a diabetic condition or peripheral vascular disease. Additionally, treatment for cramping of the feet, bunions and muscle trauma are covered only when Medically Necessary.

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, for Members residing in California, contact your Primary Care Physician or Health Net's Customer Contact Center. In Mexico, contact SIMNSA at **(011-52-664) 683-29-02 or 683-30-05 or 1-619-407-4082.** Physicians at your Physician Group, Health Net or SIMNSA will review your request in accordance with Health Net's or SIMNSA's procedures and timelines as stated in the second opinion policy. You may obtain a copy of this policy from Health Net's 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.

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 "Schedule of Benefits and Copayments" section.

Treatment Related to Rape or Sexual Assault
This Plan provides Covered Benefits for a Member who is treated following a rape or sexual assault. These services include Emergency Services and Care, Follow-Up Care, medical care, behavioral health care. These services will be covered in full through the Salud Network. These services will be covered in full through SIMNSA for the first nine months after the Member initiates treatment.

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.

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

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

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

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

This benefit is provided in Mexico in a Hospital Skilled Nursing Facility unit.

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.

Gender Affirmation Surgery and Services
Medically Necessary gender affirmation services, including, but not limited to, mental health evaluation and treatment, pre-surgical and post-surgical hormone therapy, fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy, and orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery) for the treatment of gender dysphoria or gender identity disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender affirmation surgery or a documented gender affirmation surgery treatment plan. Medical necessity for transgender services will be based on recommendations set forth in the Standards of Care of the World Professional Association for Transgender Health.

Reasonable travel, lodging and meal costs, as determined by Health Net, for a Member to undergo an authorized gender affirmation surgery are covered (companion not covered).

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

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the HN qualified provider up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Member not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

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

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

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net. Transgender surgery is not covered in Mexico.

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

Travel Benefit for Specific Services
Travel and lodging coverage for eligible medically necessary services including, but not limited to, termination of pregnancy services, complex surgeries, and cancer care may be covered.

If you live 50 miles or more from the nearest authorized facility providing these services, you are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by Health Net.

Contact Health Net by calling the Health Net Customer Contact Center at the phone number on your Health Net ID card to find out if such services are eligible for travel expenses reimbursement.

Approved travel-related expenses will be reimbursed as follows, up to a maximum of $5,000 per occurrence:

- Transportation for the Member to and from the facility up to $130 per trip for a maximum of four (4) trips (air or other travel expenses.
- Hotel accommodations for the Member not to exceed $100 per day, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip or up to four (4) days for the surgery visit.
- Mileage, $0.21 per mile for medical expenses.
- Including companion travel benefits for both parent/guardians when patient is under 18, includes transportation, lodging, and meals.

Travel benefits are not covered in Mexico or through SIMNSA.

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.

Vision and Hearing Examinations
Vision and hearing examinations for diagnosis and treatment, including refractive eye examinations, are covered as shown in the "Schedule of Benefits and Copayments" section. Preventive vision and hearing screening are covered as Preventive Care Services.

The plan does not cover vision therapy, eyeglasses or contact lenses. However, implanted lenses that replace organic eye lenses are covered.

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.

Outpatient Prescription Drugs Benefits

In the United States, The Outpatient Prescription Drug Program is provided by **CVS Caremark**. Please refer to your **CVS Caremark** Prescription Drug Program Evidence of Coverage booklet, or call **CVS Caremark** Customer Care at **1-833-291-3649** (TTY: 711) for complete details of prescription drug, preventive drug and women's contraceptive drug coverage.

In Mexico, Prescription Drugs are covered when dispensed by a SIMNSA Participating Pharmacy and prescribed by a SIMNSA Physician or an emergent or urgent care Physician. To obtain Prescription Drugs in Mexico, the Prescription Drug Order must be written by a Provider in Mexico.

Chiropractic Services and Supplies

Please read the "Chiropractic Services and Supplies Exclusions and Limitations" portion of this section.

Chiropractic Services provided by American Specialty Health Plans of California, Inc. (ASH Plans) are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," section.

Contracted Chiropractors will provide Chiropractic Services for treatment or

maintenance of a medical condition. Chiropractic Services to treat active symptoms, maintain a patient in a stable condition or prevent a relapse are covered as determined medically necessary by the Contracted Chiropractor to the extent consistent with professionally recognized standards of care. You may access any Contracted Chiropractor without a referral from a Physician or your Primary Care Physician.

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

- You may receive Emergency Chiropractic Services from any chiropractor, including a non-Contracted Chiropractor; and
- If covered Chiropractic Services are not available and accessible to you in the county in which you live, you may obtain covered Chiropractic Services from a non-Contracted Chiropractor who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

The following benefits are provided for Chiropractic Services:

Office Visits

- A new patient exam or an established patient exam is performed by a Contracted Chiropractor for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic 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 Chiropractor 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 Chiropractic Services. The established patient exam must be Medically Necessary.
- Subsequent office visits may involve a chiropractic manipulation (adjustment), a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same course of treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Second Opinion

If you would like a second opinion with regard to Covered Benefits provided by a Contracted

Chiropractor, you will have direct access to any other Contracted Chiropractor. Your visit to a Contracted Chiropractor 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 Chiropractor.

However, a visit to a second Contracted Chiropractor 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 Chiropractor by another Contracted Chiropractor (the first Contracted Chiropractor). The visit to the first Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests
X-rays and laboratory tests are payable when prescribed by a Contracted Chiropractor as Medically/Clinically Necessary Chiropractic Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH Plans to provide those services. A Copayment is not required.

X-ray second opinions are covered only when performed by a radiologist to verify suspected tumors or fractures.

Chiropractic Appliances
Chiropractic Appliances are payable when prescribed by a Contracted Chiropractor for up to the maximum benefit shown in the "Schedule of Benefits and Copayments," section and obtained from an ASH Plan affiliated supplier.

Chiropractic Services and Supplies Exclusions and Limitations

The exclusions and limitations in the "Exclusions and Limitations" section also apply to Chiropractic Services.

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

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

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

Anesthesia
Charges for anesthesia are not covered.

Diagnostic Radiology
Coverage is limited to x-rays. No other diagnostic radiology (including 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 Chiropractic Services
Chiropractic care that is (a) investigatory; or (b) an unproven Chiropractic Service that does not meet generally accepted and professionally recognized standards of practice in the chiropractic 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.

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

Non-Contracted Provider
Services or treatment rendered by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a referral by ASH Plans.

Nonchiropractic Examinations
Examinations or treatments for conditions unrelated to Musculoskeletal and Related Disorders are not covered. This means that physiotherapy not associated with spinal, muscle and joint manipulation, is not covered.

Out-of-State Services
Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.

Services Not Within License
Services that are not within the scope of license of a licensed chiropractor in California.

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.

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

Vitamins
Vitamins, minerals, nutritional supplements or other similar products, including when in combination with a prescription product, are not covered.

Acupuncture Services

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

Acupuncture Services provided by American Specialty Health Plans of California, Inc. (ASH Plans) are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section.

Contracted Acupuncturist will provide Acupuncture Services for treatment or maintenance of a medical condition. Acupuncture Services to treat active symptoms, maintain a patient in a stable condition or prevent a relapse are covered as determined Medically Necessary by the Contracted Acupuncturist to the extent consistent with professionally recognized standards of care. 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:

- You may receive Emergency Acupuncture Services from any acupuncturist, including a non-Contracted Acupuncturist; and
- 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.

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 may involve acupuncture treatment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.

- Adjunctive therapy may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture.

Only the treatment of Pain, Nausea or Musculoskeletal and Related Disorders is covered, provided that the condition may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

Covered Pain and Musculoskeletal and Related Disorders include:

- Tension-type headache; migraine headache with or without aura;

- Hip or knee joint Pain associated with Osteoarthritis (OA);

- Other extremity joint pain associated with OA or mechanical irritation/inflammation when chronic and unresponsive to standard medical care;

- Other Pain syndromes involving the joints and associated soft tissues;

- Musculoskeletal cervical spine, thoracic spine, and lumbar spine Pain.

Covered Nausea includes:

- Nausea associated with pregnancy (only when co-managed);

- Post-operative Nausea/vomiting (generally within the first 24 hours after surgery) or post-discharge Nausea/vomiting (generally within a few days after post-operative discharge); (only when co-managed);

- Nausea associated with chemotherapy; (only when co-managed).

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/Necessary as appropriate or classified as experimental, and/or being in the research stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a Life-Threatening or Seriously Debilitating condition and ASH plans denies coverage based on the determination that the therapy is experimental, you may be able to request an Independent Medical Review of ASH Plans' determination. You should contact ASH Plans at **1-800-678-9133** for more information.

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

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

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

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

Durable Medical Equipment
Durable Medical Equipment is not covered.

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

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

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 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 by Health Net or SIMNSA.

Telehealth services for Mental Health or Substance Use Disorder are provided through the Select Telehealth Services Provider as described under "Telehealth Consultations Through the Select Telehealth Services Provider" in the "Medical Services and Supplies" portion of this "Covered Services and Supplies" section.

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

Certain services and supplies for Mental Health or Substance Use Disorders require prior authorization by Health Net or SIMNSA to be covered. The services and supplies 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-affirmation surgery;

- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing, intensive Outpatient services, and gender-affirmation surgery; and
- Behavioral health treatment for pervasive developmental disorder or autism (see below under “Outpatient Services”).

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 the 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 an 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.healthnet.com/calpers or contact Health Net at the Health Net Customer Contact Center phone number shown on your Health Net ID card.

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

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 geo-graphic 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 identi-fied 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 deliv-ered by providers who are licensed in accordance with California law (or Mexico law for services provided in Mexico) and are acting within the scope of such license or as otherwise authorized under California law.

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

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: Includes outpatient crisis intervention, short-term evaluation and therapy, medication management (including detoxification), 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: Including psychological and neuropsychological testing when necessary to evaluate a Mental Health or Substance Use Disorder, intensive outpatient care program, day treatment, partial hospitalization program, and other outpatient procedures/services including, but not limited to, laboratory services or rehabilitation when provided for Mental Health or Substance Use Disorder conditions. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. A partial hospitalization/day treatment program is a treatment program that may be freestanding or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

- Behavioral health treatment for pervasive developmental disorder or autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with pervasive developmental disorder or autism, as shown in the "Schedule of Benefits and Copayments" section under "Mental Health or Substance Use Disorder Benefits."

- The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.

- A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to Health Net.

- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The

treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.

- The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

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

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

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 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 of 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.

All services received for Members in Mexico must be provided by a SIMNSA Mental Health contracting participating provider. For more information regarding Mental Health or Substance Use Disorder Care, please contact SIMNSA at **(011-52-664) 683-29-02 or 683-30-05 or 1-619-407-4082**.

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

Nonstandard Therapies
Hypnotherapy services are covered in California 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.

All services received for Members in Mexico must be provided by a SIMNSA Mental Health contracting participating provider. For more information regarding Mental Health or Substance Use Disorder Care, please contact SIMNSA at **(011-52-664) 683-29-02** or **683-30-05 or 1-619-407-4082**.

EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

Coverage of Approved Clinical Trials does not include the following:

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

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

Cosmetic Services, Supplies, or Surgeries
This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in the "Covered Services and Supplies" section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in the "Covered Services and Supplies" section, or as required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this *EOC* in the "Covered Services and Supplies" section.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve

function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by Physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this *EOC* in the "Covered Services and Supplies" section.

Custodial or Domiciliary Care
This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in the "Covered Services and Supplies" section or as required by law.

This exclusion does not apply to the following:

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

Dental Services
This Plan does not cover dental services or supplies, except as described in this EOC in the "Covered Services and Supplies" section or as required by law.

Dietary or Nutritional Supplements
This Plan does not cover dietary or nutritional supplements, except as described in this EOC in the "Covered Services and Supplies" section or as required by law.

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

Experimental Services or Investigational Service
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.

Vision Care

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

Hearing Aids

This Plan does not cover hearing aids, except as described in this *EOC* in the "Covered

Services and Supplies" section or as required by law.

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

Nonlicensed or Noncertified Providers
This Plan does not cover treatments or services rendered by a nonlicensed or noncertified Health Care Provider, except as described in this *EOC* in the "Covered Services and Supplies" section or as required by law.

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

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

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of 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:
  - Insulin,
  - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
  - Over-the-counter drugs for reversal of an opioid overdose, or
  - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

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

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

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

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

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

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

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

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

Weight Control Programs and Exercise Programs
This Plan does not cover weight control programs and exercise programs, except as described in this EOC in the "Covered Services and Supplies" section or as required by law.

GENERAL PROVISIONS

When the Plan Ends

The Group Service Agreement specifies how long this Plan remains in effect.

If you are totally disabled on the date that the Group Service Agreement is terminated, benefits will continue according to the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section.

When the Plan Changes

Subject to notification and according to the terms of the Group Service Agreement, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions and eligibility provisions.

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under the "Eligibility, Enrollment and Termination" section in the subsection, "When Coverage Ends" regarding termination for nonpayment, Health Net will not provide notice of such changes to Plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to Plan Subscribers.

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

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

Members' Rights, Responsibilities and Obligations Statement

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

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's Member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in

your Plan's network, including one with a specialist.

- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - Full and equal access, as other members of the public, to medical facilities.
  - Extra time for visits if you need it.
  - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.

- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing

health care services or have questions about your Plan.

- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility 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 Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-Covered Benefits.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Grievance, Appeals, Independent Medical Review, CalPERS Administrative Review and Hearing Process and Arbitration.

Member Dispute Resolution

Pharmacy Grievance Procedures
All pharmacy benefits are managed by CVS Caremark. Please refer to your CVS Caremark Pharmacy Evidence of Coverage booklet for Pharmacy grievance procedures or you may contact CVS Caremark Customer Care at **1-833-291-3649** or (TTY: **711**).

Medical Grievance Procedures

SIMNSA
Members who obtain care through SIMNSA in Mexico have certain grievance rights, as described below, but do not have access to the same legal rights and remedies regarding grievance processing as those Members who obtain care through the Salud Network in the U. S. These differences are noted below.

Health Net has established and administers the Health Net Member grievance procedure. This process includes a detailed description of the roles and responsibilities that Health Net, contracting Physician Groups participating in the Salud Network and SIMNSA have in resolving Health Net Member grievances. This includes a detailed description of any and all delegation and oversight that Health Net monitors with respect to contracting Physician Groups or SIMNSA. Health Net does not delegate to SIMNSA any level of appeals or grievance resolution for any Health Net Member seeking care through or in the Salud Network.

SIMNSA, contracting Physician Groups and Health Net shall establish and maintain grievance policies and procedures and shall make a written summary of such policies and procedures available to Health Net, employees and contracting Physicians of Physician Groups and SIMNSA and to Members. Such summary shall include the current address and telephone number for registering a complaint through the Physician Group's or SIMNSA's

grievance procedures in accordance with the Health Net standards.

Physician Groups and SIMNSA shall report to Health Net all Health Net Member appeals by type of appeal or grievance and timeliness of appeal or grievance resolution on a quarterly basis. Health Net will periodically audit all delegated appeals and grievances to ensure that the appeals and grievances are being handled in a timely and appropriate manner.

In the event any complaint or grievance of a Health Net Member cannot be settled through the appeal or grievance process, such matter shall be submitted to binding arbitration in accordance with the terms of the Member's Benefits Disclosure and *Evidence of Coverage*. In that event, the parties hereto agree to cooperate and, at the request of a party, participate in any arbitration proceedings arising there from and, subject to either party's right to seek judicial review thereof in accordance with the terms of the Health Net Benefits Disclosure and *Evidence of Coverage*, to abide by all provisions of any final award rendered as a result of such proceedings.

Health Net
You, an authorized representative, or a provider on behalf of you, may request to file an appeal or grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD), and must be submitted in one of the following ways:

- Call Customer Service at **1-888-926-4921**; or
- Fill out a Member Grievance Form on the Health Net website https://www.healthnet.com/calpers; or
- In writing by sending information to:

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

  Or in Mexico-SIMNSA

  SIMNSA
  c/o International Healthcare, Inc.
  303 H Street, Suite 390
  Chula Vista, CA 91910
  1-800-424-4652
  1-619-407-4082
  Or

  SIMNSA
  206 Paseo Rio Tijuana 406
  1er Piso-Edificio Allen Lloyd
  Tijuana, Baja California
  Mexico, 22320

  Tel. (011-52-664) 683-29-02
  and 683-30-05

The grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the Health Net ID card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the Service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale.

If your concern involves the chiropractic or acupuncture program, call the Health Net Customer Contact Center at 1-888-926-4921 or write to:

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

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

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

We will:

- For grievances filed for reasons other than cancellation or nonrenewal of coverage, confirm in writing within five calendar days that we received your request. For grievances filed regarding cancellation, rescission or nonrenewal of coverage, confirm in writing within three calendar days that we received your request.
- For grievances filed for reasons other than cancellation or nonrenewal of coverage, review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, 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.

You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Customer Service at **1-888-926-4921**.

If Health Net upholds the ABD, that decision becomes the Final Adverse Benefit Determination (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the Independent External Review process described below
- For FABDs involving benefits, you may pursue the Department of Managed Health Care (DMHC) process as described in the DMHC section. or you may initiate binding arbitration, as described under Binding Arbitration.

Urgent Decision

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Health Net determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or

ability to regain maximum function; **OR**

- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A physician with knowledge of your medical condition determines that your grievance is urgent.

If Health Net determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request.

Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an Independent Medical Review (IMR), at **1-888-466-2219** (TDD **1-877-688-9891**), without first filing an appeal with us.

Experimental or Investigational Denials
Health Net does not cover experimental or investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is an Experimental Service or an Investigational Service and you meet the eligibility criteria set out below, you may request an IMR of Health Net's decision from the DMHC. Note: DMHC does not require you to exhaust Health Net's appeal process before requesting an IMR of ABD's based on Investigational Services or Experimental Services. In such cases, you may immediately contact DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process, you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form by calling us at 1-888-926-4921 or write to:

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

To qualify for this review, all of the following conditions must be met:

You have a Life-Threatening or Seriously Debilitating condition. The condition meets either or both of the following descriptions:

- A Life-Threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A Life-Threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
- A Seriously Debilitating condition or disease is one that causes major irreversible morbidity.

Your medical group/physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this plan that is more beneficial than the proposed treatment.

The proposed treatment must either be:

- Recommended by a Health Net provider who certifies in writing that the treatment is

likely to be more beneficial than standard treatments; or

- Requested by you or by a licensed board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources;

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

- Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

- Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

- Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

- Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

- Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review or within 24 hours if your condition involves an imminent and serious threat to your health we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional

information submitted by you or your doctor. Any newly developed or discovered relevant medical records that we or an Health Net provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your doctor determines that the proposed treatment would be significantly less effective if not provided promptly).

Independent Medical Review Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed, in whole or in part, by Health Net or one of its providers because the service is deemed 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 this review.

You have the right to provide information in support of the request for an IMR. Health Net must provide you with an IMR application form and Health Net's FABD 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:

The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have had urgent care or Emergency Services and Care that a provider determined was medically necessary, or
   (c) You have been seen by a Health Net provider for the diagnosis or treatment of the medical condition for which you want an IMR;
2. The disputed health care service has been denied, changed, or delayed by us or your medical group, based in whole or in part on a decision that the health care service is deemed not medically necessary; and
3. You have filed a complaint with us or your medical group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review, you do not have to participate in our complaint process. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72 hour grievance review period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of Health Net. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor Health Net will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing,

and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance Procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds Health Plan's FABD, you may have additional review rights under the CalPERS Administrative Review section. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service.

For more information regarding the IMR process or to request an application form, please call Customer Service at 1-888-926-4921 or visit our website at www.healthnet.com/calpers.

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 **1-888-926-4921** (TTY users call **1-877-688-9891**) 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 an appeal 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 an 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.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, Grievance Procedures, experimental or investigational Denials, Independent Medical Review Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. Eligibility issues

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account Management Division
Attn: Enrollment Administration
P.O. Box 942715
Sacramento, CA 94229-2715

888 CalPERS (or **888**-225-7377) CalPERS Customer Service and Outreach Division toll free telephone number**1-916-795-1277** fax number

2. Coverage Issues

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this EOC booklet. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of Health Net's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, or proceed to binding arbitration.

Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may not request a

CalPERS Administrative Review if you decide to proceed to binding arbitration.

3. Malpractice and Bad Faith

You must proceed directly to binding arbitration.

4. Disputed Health Care Service Issue

A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not medically necessary, or experimental or investigational.

If you are dissatisfied with the outcome of Health Net's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the DMHC or IMR determination, or you may proceed to binding arbitration. If you choose to proceed to binding arbitration, you may not request a CalPERS Administrative Review.

Binding Arbitration (Not available for claims involving Covered Benefits that were appealed through the CalPERS Administrative Review and Hearing Process)
If you submit a dispute you have with Health Net, except those described above as to the CalPERS Administrative Review and Hearing Process, to final and binding arbitration, you will be bound by the outcome. Likewise, Health Net agrees to be bound by the outcome of the arbitration of 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 that you submit to arbitration and thereby both parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described below, 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, and you do not use the CalPERS Administrative Review and Hearing Process, Health Net uses binding 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 a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

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

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

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

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

CalPERS Administrative Review

If you remain dissatisfied with Health Net's determination, the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust Health Net's internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC's determination or, the IMR determination letter, in cases involving a Disputed Health Care Service, or experimental or investigational determination.

Health.appeals@CalPERS.ca.gov; Or, the request may be mailed to:
CalPERS Health Benefit Compliance and Appeals Unit
Attn: Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

You are encouraged to include a signed Authorization to Release Health Information (ARHI) form in the request for an Administrative Review, which gives permission to the Plan to provide medical documentation to CalPERS. If you would like to designate an Authorized Representative to represent yourself in the Administrative Review process, complete Section IV. Election of Authorized Representative on the ARHI form. You must complete and sign the form. An ARHI assists CalPERS in obtaining health information needed to make a decision regarding your request for Administrative Review. The ARHI form will be provided to you with the FABD letter from Health Net.

If you are planning to submit information to CalPERS that Health Net may have regarding your dispute with your request for Administrative Review, please note that Health Net may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after Health Net submits the information it has regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if you requests an IMR at the same time you submit a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a Member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

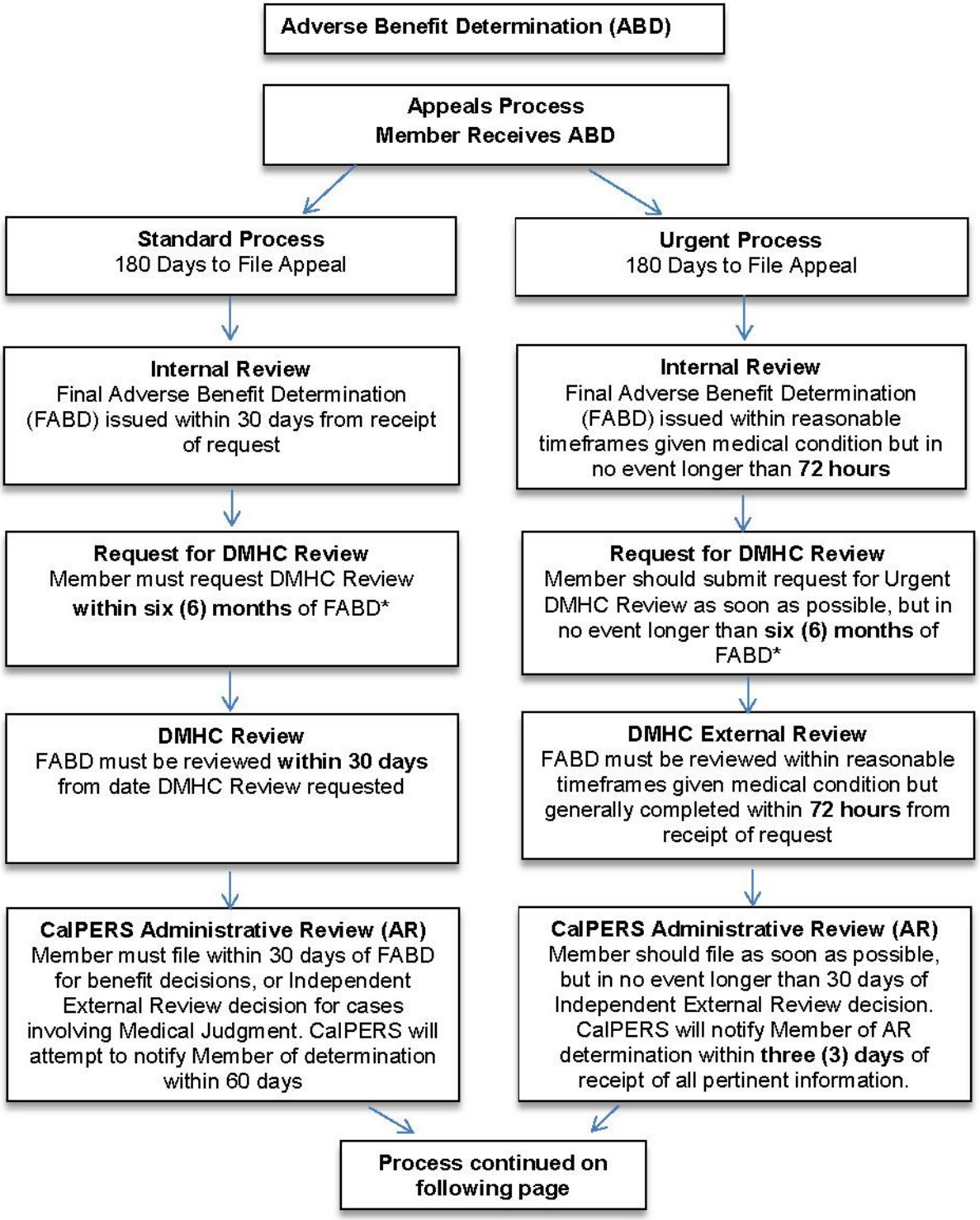
A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

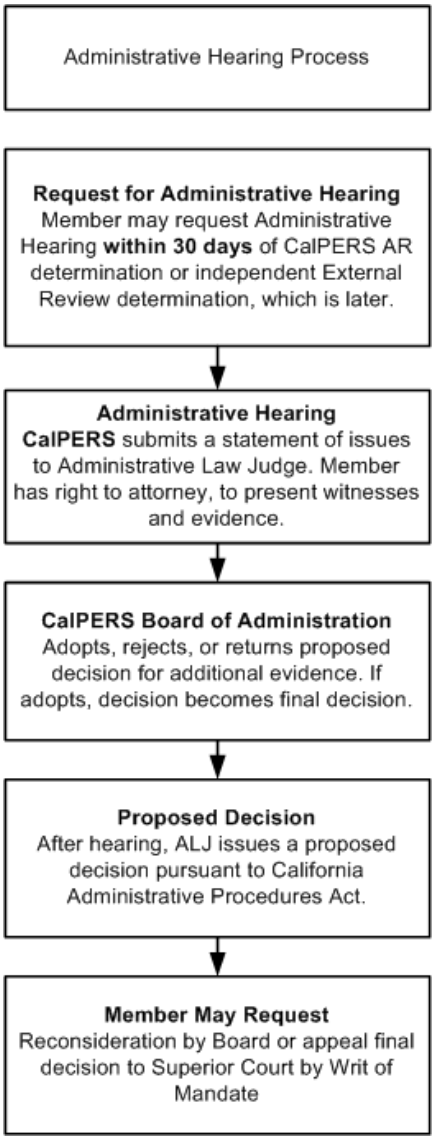
- **Right to records, generally**. You may, at their own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege**. Communication between an attorney and a client, whether oral or in writing, will not be

disclosed under any circumstances.

- **Attorney Representation**. At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at their own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants**. At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.



*For FABDs that involve "Medical Judgment", the Member must request a DMHC Review prior to submitting a CalPERS Administrative Review


Administrative Hearing Process
Request for Administrative Hearing
Member may request Administrative Hearing **within 30 days** of CalPERS AR determination or independent External Review determination, which is later.
Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.
CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence. If adopts, decision becomes final decision.
Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.
Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

Definitions

Adverse Benefit Determination (ABD) - a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Determination of an individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or
- Determination that a benefit is an Experimental Service, an Investigational Service, or not Medically Necessary or appropriate.

Appeal – complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this EOC, including an adverse benefit determination as set forth under the ACA (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

Authorized Representative - means an individual designated by you to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by you in writing on a form approved by Health Net.

Disputed Health Care Service - any Health Care Service eligible for coverage and payment under your Health 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 deemed not Medically Necessary.

Grievance – complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

Life-Threatening Condition – having a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

Seriously Debilitating Condition – having a disease or condition that could cause major irreversible morbidity.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to 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:

- 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 contracting Physician Group.
- Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting 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 contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances 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. In the U.S., 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 Services or Experimental Services during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational Services or Experimental Services if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

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

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If Health Net denies, modifies or delays coverage for your requested treatment on the basis that it is an Experimental Service or an Investigational Service, you may request an Independent Medical Review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" above in this "General Provisions" section for additional details.

Medical Malpractice Disputes

Health Net and the Health Care Providers that provide services to you through this Plan are each responsible for their own acts or

omissions and are ordinarily not liable for the acts or omissions, or costs of defending others.

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all Covered Benefits that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries Health Net, SIMNSA 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.
- 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 (PIP), 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 receive from the responsible parties or, from any other source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

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

- The amount of the reimbursement that you owe Health Net or the 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 by a prorated 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, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Evidence of Coverage and applicable law.*

Surrogacy Arrangements
A Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to Health Net
If you enter into a surrogacy arrangement, you must pay us for Covered Benefits you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments you and/or any of your family members are entitled to receive under the surrogacy arrangement. You also agree to pay us for the Covered Benefits that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if you provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to Health Net in advance of delivery, you will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments
By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Duty to Cooperate
Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

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

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to your surrogacy arrangement and to satisfy Health Net's rights.

You must do nothing to prejudice the health plan's recovery rights.

You must also provide us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Relationship of Parties
Contracting Physician Groups, SIMNSA, 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 in the Salud Network, SIMNSA, 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 Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees or of Salud Network or SIMNSA Provider, or 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.

Continuity of Care upon Termination of Provider Contract
If Health Net's contract with a Salud Network or SIMNSA participating Physician Group or other provider is terminated, Health Net will transfer any affected Members to another Salud Network or SIMNSA participating 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 five days after the effective date of the contract termination.

In addition, a Member may request continued care from a 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 pregnancy, whichever occurs later;
- A newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider’s contract termination. You must request continued care within 30 days of

the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

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

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

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

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

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

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

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

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

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

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

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

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

Definitions

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

- **Plan**--A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.
- **"Plan" includes** group insurance, closed panel (HMO, PPO, or EPO) coverage, or other forms of group or group-type coverage (whether

insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care. *(Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits please refer to the "Government Coverage" portion of this "General Provisions" section.)*

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

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

- **Primary Plan or Secondary Plan**--The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.
- When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.
- **Allowable Expense**--This concept means a Health Care Service or expense, including Copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

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

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

Exception:

- If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary

fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

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

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

- The amount a benefit is reduced by the Primary Plan because of a Member does not comply with the plan provisions is not an Allowable Expense. Examples of these provisions are second surgical opinions, Prior Authorization of admissions and preferred provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

Order of Payment Rules--The first of the following rules that describes which Plan pays

its benefits before another Plan is the rule that will apply.

- **Subscriber (Non-Dependent) vs. Dependent**--The Plan that covers the person other than as a Dependent, for example as an employee, subscriber, or retiree, is primary and the Plan that covers the person as a Dependent is secondary.
- **Child Covered By More Than One Plan**--The order of payment when a child is covered by more than one Plan is:
- **Birthday Rule**--The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
- The parents are married; or
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
- **Court Ordered Responsible Parent**--If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
- **Parents Not Married, Divorced, or Separated**--If the parents are not married or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The Plan of the Custodial Parent
- The Plan of the spouse of the Custodial Parent
- The Plan of the noncustodial parent
- The Plan of the spouse of the noncustodial parent
- **Active vs. Inactive Employee**--The Plan that covers a person as an employee who is neither laid off nor retired (or their Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or their Dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

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

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

- **COBRA Continuation Coverage**--If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state

law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's Dependent) is primary and the continuation coverage is secondary. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

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

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

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

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

- **Equal Sharing**--If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the plans.

Effect on the Benefits of This Plan

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

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

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

Right to Receive and Release Information

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

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

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

Health Net's Right to Pay Others

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

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

Recovery of Excessive Payments by Health Net

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

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

Government Coverage

Medicare Coordination of Benefits (COB)

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

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

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by your provider or by you to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN.

Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this Plan for the Covered Benefits described in this *Evidence of Coverage*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net as required under this *Evidence of Coverage*.

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare coordination of benefits, unless you are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or

Write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare and Medicaid Services
6325 Security Blvd.
Baltimore, MD 21207

Medi-Cal
Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration
Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers' Compensation

This Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers' Compensation laws.

If you require Covered Benefits or supplies and the injury or illness is work-related and benefits are available as a requirement of any Workers' Compensation or Occupational Disease Law, Salud Network or SIMNSA will provide services and Health Net will then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all Covered Benefits through a network of contracting Physician Groups or SIMNSA. Your Physician Group or SIMNSA 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 or SIMNSA at the telephone number shown on your Health Net ID card or visit our website at www.healthnet.com/calpers to obtain claim forms.

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

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

If you need to file a claim for Emergency Chiropractic Services or Emergency Acupuncture Services or for other covered Chiropractic Services or covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with ASH Plans within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
Attention: Customer Contact Center
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Chiropractic Services or covered Acupuncture Services, you may call ASH Plans at **1-800-678-9133** or you may write ASH Plans at the address given immediately above.

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

Payment of Claim

Within 30 calendar days of receipt of a claim (refer to "Notice of Claim" above), Health Net shall pay the benefits available under this Evidence of Coverage or provide written notice

regarding additional information needed to determine our responsibility for the claim.

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

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

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 contracting Physician Group personnel or a similar event.

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

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

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

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

Confidentiality of Medical Records

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

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. Effective 08.14.-2017

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

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

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

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

We will make any revised Notices available on our website, www.healthnet.com/calpers and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

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

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

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

Treatment. We may use or disclose your PHI to a Physician or other Health Care Provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.

Payment. We may use and disclose your PHI to make benefit payments for the Health Care

Services provided to you. We may disclose your PHI to another health plan, to a Health Care Provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:

- Processing claims;
- Determining eligibility or coverage for claims;
- Issuing premium billings;
- Reviewing services for medical necessity; and
- Performing utilization review of claims.

Health Care Operations. We may use and disclose your PHI to perform our health care operations. These activities may include:

- Providing customer services;
- Responding to complaints and appeals;
- Providing case management and care coordination;
- Conducting medical review of claims and other quality assessment; and
- Improvement activities.

In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must have a relationship with you for its health care operations. This includes the following:

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

Your race, ethnicity, language, sexual orientation, gender identity, and social needs information are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with California regulatory agencies, Health Care Providers, and health care oversight entities. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:

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

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

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

Other Permitted Or Required Disclosures of Your PHI:

Fundraising Activities. We may use or disclose your PHI for fundraising activities,

such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Underwriting Purposes. We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Appointment Reminders/Treatment Alternatives. We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

As Required by Law. If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

Public Health Activities. We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may 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 authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

Judicial and Administrative Proceedings. We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:

- An order of a court;
- Administrative tribunal;
- Subpoena;
- Summons;
- Warrant;
- Discovery request; or
- Similar legal request.

Law Enforcement. We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

- Court order;
- Court-ordered warrant;
- Subpoena;
- Summons issued by a judicial officer; or
- Grand jury subpoena.

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

Substance-Use Disorder Records (SUD) – We will not use or disclose your SUD records in legal proceedings against you unless:

- We receive your written consent, or
- We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.

Coroners, Medical Examiners and Funeral Directors. We may disclose Your PHI to a

coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose Your PHI to funeral directors, as necessary, to carry out their duties.

Organ, Eye and Tissue Donation. We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

- Cadaveric organs;
- Eyes; or
- Tissues.

Threats to Health and Safety. We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Specialized Government Functions. If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

- To authorized federal officials for national security and intelligence activities;
- The Department of State for medical suitability determinations; and
- For protective services of the President or other authorized persons.

Workers' Compensation. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations. We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

Research. Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

Sale of PHI. We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing. We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes. We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Impermissible Use of PHI. We will not use your language, race, ethnic background, sexual

orientation, 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, Inc.) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

Right to Revoke an Authorization. You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

Right to Request Restrictions. You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose Medical Information related to Sensitive Services provided to a Protected Individual to the Group, Subscriber, or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care. Refer to the customer service phone number on the back of your Member identification card or the plan's website for instructions on how to request confidential communication.

Right To Access and Receive Copy of Your PHI. You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless We cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, We will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Right to Amend Your PHI. You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name,

of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures. You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint. If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

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

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Right to Receive a Copy of this Notice. You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

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

Health Net Privacy Office
Telephone:1-800-522-0088
Attn: Privacy Official
Fax: **1-833-887-0151**
P.O. Box 9103
Van Nuys, CA 91409
Email: Privacy@healthnet.com

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

Privacy Officer
c/o Office of Legal Services
California Department of Health Care Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Phone: **1-916-445-4646 or 1-866-866-0602**
(TTY:TDD: 1-877-735-2929)
E-mail: Privacyofficer@dhcs.ca.gov.

FINANCIAL INFORMATION PRIVACY NOTICE

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

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect
We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, Medical Information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information
We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security
We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

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

Health Net, LLC
Attn: Privacy Official
21281 Burbank Blvd
Woodland Hills, CA 91367

Please call the toll-free phone number on the back of your ID card or contact Health Net at **1-888-926-4921**.

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Musculoskeletal and Related Disorders, Nausea and Pain. Acupuncture Services include services rendered by an acupuncturist for the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. Acupuncture Services do not include any other services, including, without limitation, services for treatment of asthma or addiction (including, but not limited to, smoking cessation).

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.

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 Chiropractic and Acupuncture Services through a network of Contracted Chiropractors and 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 Trials means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:

- The National Institutes of Health.
- The federal Centers for Disease Control and Prevention.
- The Agency for Healthcare Research and Quality.
- The federal Centers for Medicare and Medicaid Services.
- A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
- A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of

the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have 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.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

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.

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

Chiropractic Appliances are support type devices prescribed by a Contracted Chiropractor specifically for the treatment of a Musculoskeletal and Related Disorder. The devices this Plan covers are limited to elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar supports, lumbar cushions, Orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic Services are chiropractic manipulation services provided by a Contracted Chiropractor (or in case of emergency services, by a non-Contracted Chiropractor) for treatment or diagnosis of Musculoskeletal and Related Disorders and Pain syndromes. These services are limited to the management of Musculoskeletal and Related Disorders and Pain syndromes primarily through chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. This includes: (1) differential diagnostic examinations and related diagnostic x-rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; (2) the follow-up office visits which during the course of treatment must include the provision of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

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

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

Copayment is the amount that a Member is required to pay for specific Covered Benefits. 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 a group agreement and which are described in this *Evidence of Coverage* or under California health plan law.

Cosmetic surgery is a surgery performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Member.

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

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

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.

Dependent is a Subscriber's spouse, domestic partner, as defined in California Government Code section 22770, or child, as defined in Title 2, California Code of Regulations, Section 599.500.

Durable Medical Equipment serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).

Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Withstands repeated use.

Is appropriate for use in a home setting.

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

Emergency Acupuncture Services are Covered Benefits that are Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system, or causing Pain or Nausea which manifests itself

by acute symptoms or sufficient severity such that a person could reasonably expect that a delay of immediate Acupuncture Services could result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Acupuncture Services constitute Emergency Acupuncture Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's Independent Medical Review process.

Emergency Chiropractic Services are Covered Benefits that are Chiropractic Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain such that a person could reasonably expect that a delay of immediate Chiropractic Services could result in any of the following: (1) place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decrease the likelihood of maximum recovery. ASH Plans shall determine whether Chiropractic Services constitute Emergency Chiropractic Services. ASH Plans' determination shall be subject to ASH Plans' grievance procedures and the Department of Managed Health Care's Independent Medical Review process.

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.

Employer means any public agency or association in which the majority of employees were employed within the Health Net Service Area.

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.

Group is the business organization (usually an Employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Care Services (including Behavioral Health Care Services) are those services that can only be provided by an individual licensed as a Health Care Provider by the state of California to perform the services (or under Mexico law for services provided in Mexico), acting within the scope of their license.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Salud Network (Salud Network) is the network of contracting Physician Groups and Hospitals Health Net has established to provide care to Members who live or work within the Health Net Salud Service Area in California (see definition of Health Net Salud Service Area below).

Health Net Salud Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to market the Salud con Health Net HMO Plan, enroll Members and contract with Health Care Providers to participate in the Salud Network. This Service Area also includes northern Baja California (extending 50 miles south of the California - Mexico - border) in which Health Net has contracted with SIMNSA to provide health care to eligible Dependents of those Members who subscribe to the Salud con Health Net HMO Plan in California.

To enroll in the Salud con Health Net HMO Plan, Subscribers must work or live in an approved service area from which a Subscriber has reasonable access to Salud Network providers. Additionally, enrollment is restricted to:

- Eligible Dependents who live or work in the Health Net Salud Service Area provided such Dependents have reasonable access to Salud Network providers from their residence or work location.
- Eligible Dependents living in Mexico who live or work in Baja California within 50 miles of the California - -Mexico border (see also the definition of "SIMNSA Service Area"), as allowed by group eligibility requirements.

Please refer to the "Health Net Salud Plan Service Area" section for more information on the approved areas of California and Mexico where this Salud Con Health Net Plan is available.

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 in the United States.

Hospital is a legally operated facility licensed by the state where it is located as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare. Hospitals located in the Republic of Mexico are licensed by the appropriate governmental agency in that country.

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Infertility means a condition or status characterized by any of the following:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in item 3 below.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Inpatient is an individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

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.

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 Plan and for whom coverage is active or live.

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.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group or SIMNSA.

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*.

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Contracted Acupuncturist in accordance with professionally recognized standards of practice.

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

Open Enrollment Period is a fixed time period of each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible Dependents. Enrolled Members can also change Physician Groups at this time.

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

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

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

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

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Benefits for each Calendar Year. Copayments, which are paid toward certain Covered Benefits, are not applicable to your Out-of-Pocket Maximum. These exceptions are specified in the "Out-of-Pocket Maximum" section of this *Evidence of Coverage*.

Outpatient is an individual receiving services under the direction of a plan provider, but not as an inpatient.

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, or Substance Use Disorder rehabilitation services.

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental Health Care Services. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Health or Substance Use Disorder rehabilitation services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) licensed to practice medicine or osteopathy in the U.S. or in Mexico.

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 means the medical group that provides or arranges for all covered medical care for Members. Physician Groups contracting with the Salud Network provide covered medical care for eligible individuals in California. Sistemas Medicos Nacionales S.A. de C.V. (SIMNSA) provides the medical delivery network for services in Mexico. It may be referred to as a "contracting Physician Group" or "participating Physician Group (PPG)."

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

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

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

Primary Care Physician is a Member Physician who coordinates and controls the delivery of Covered Benefits 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 enumerated health care Specialists must be designated as the Primary Care Physician.

Prior Authorization is the approval process for certain services and supplies. To obtain a copy of Health Net's Prior Authorization requirements, call the Customer Contact Center telephone number listed on your Health Net ID card.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an Inpatient or

Outpatient setting, or in a noninstitutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Protected Individual means any adult covered by the Subscriber's Health Care Service plan or a minor who can consent to a Health Care Service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A health care service plan shall not require a Protected Individual to obtain the Group, Subscriber, or other Member'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: (1) Provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider; (2) Is supervised by a Qualified Autism Service Provider; (3) Provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) Is 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 (5) Is

either of the following: i. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; or ii. If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional; and (6) Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

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

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.

Sistemas Medicos Nacionales S.A. de C.V. (herein called SIMNSA) is the entity contracted with Health Net to provide Members with access to medical care through a network of contracting Physicians, Hospitals and ancillary providers located in the SIMNSA Service Area in Mexico.

SIMNSA Providers are providers operating in approved regions of Mexico. A Member who utilizes the services of a contracting Physician Group or Physician in Mexico will be using a SIMNSA Provider.

SIMNSA Service Area is the geographic area extending 50 miles into Baja California from the California - Mexico border in which eligible Dependents of Subscribers of the Salud con Health Net HMO Plan reside.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, the facility must be approved as a participating Skilled Nursing Facility under the Medicare program where such standards are applicable. This benefit is provided for Members in Mexico in a Hospital Skilled Nursing Facility unit.

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.

Specialty Drugs are drugs that are biologics, 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) for a one-month supply.

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Subscriber is the person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

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 licensed to provide Substance Use Disorder detoxification services or rehabilitation services.

Telehealth Services means the mode of delivering Health Care Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous

interactions and asynchronous store and forward transfers.

For the purposes of this definition, the following apply:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the Health Care Provider for telehealth at a distant site without the presence of the patient.
- "Distant site" means a site where a Health Care Provider for telehealth who provides Health Care Services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time Health Care Services are provided via telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a Health Care Provider for telehealth located at a distant site.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Benefits shall be provided for the duration of a Terminal Illness.

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.

HEALTH NET SALUD PLAN SERVICE AREA

Health Net Salud Service Area in California
You are eligible to enroll as a Subscriber or dependent in this Salud Con Health Net Plan if you live or work in the areas described below, provided that you meet any additional eligibility requirements of the Group.

Los Angeles County
You must live or work in Los Angeles County.

Exception: This Salud con Health Net Plan is not available in the following zip Codes:

90090, 91310, 91321, 91322, 91350, 91351, 91354, 91355, 91380, 91381, 91382, 91383, 91384, 91385, 91386, 91387, 91390, 93510, 93532, 93534, 93535, 93536, 93539, 93543, 93544, 93550, 93551, 93552, 93553, 93563, 93584, 93586, 93590, 93591, 93599, 90189, 90834, 90835

San Diego County
You must live or work in San Diego County.

Exception: This Salud con Health Net Plan is not available in the following zip Codes:
91905, 91906, 91934, 91962, 91963, 91380, 92004, 92036, 92066, 92086, 91987, 92096

Orange County
You must live or work in Orange County.

San Bernardino County
You must live or work in the following zip codes:

91701,91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91786, 92313, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92331, 92334, 92335, 92336, 92337, 92344, 92345, 92346, 92350, 92352, 92354, 92357, 92358, 92359, 92369, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92391, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423, 92427

Riverside County
You must live or work in the following zip codes:

91752, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92313, 92514, 92516, 92517, 92518, 92519, 92521, 92522, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92570 92571, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883

Imperial County:
You must live or work in Imperial County.

Kern County
CVS MinuteClinic is not available in Kern County. You must live or work in the following zip codes:

93263, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93314

Health Net Salud Service Area in Mexico
Eligible dependents must live or work in Baja California within 50 miles of the United States – Mexico border.

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 translation 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 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

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

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

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

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

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

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

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

Vietnamese

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

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

FLY017549EH00 (12/17)

NOTICE OF NONDISCRIMINATION

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Health Net Customer Contact Center at
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-888-926-4921 (TTY: 711)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103
Customer Contact Center 1-800-675-6110 (TTY: 711)
California Relay 711

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

Electronically: Send an email to SM_Section1557Coord@centene.com This notice is available at Health Net website: https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html
If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

CONTACT US

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
1-888-926-4921

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

www.healthnet.com/calpers

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