Salud HMO y Más

Evidence of Coverage and Plan Document
for the Basic Plan

Effective January 1, 2017

Legislative and Administrative changes effective January 1, 2017
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.

If you have a web-enabled smartphone, you've got everything you need to track your health plan details. Take the time to download Health Net Mobile. You'll be able to carry your ID card with you, easily find details about your plan, store provider information for easy access, search for doctors and hospitals, or contact us at any time. It's everything you need to track your health plan details – no matter where you are as long as you have your smartphone handy.

We look forward to serving you. Contact us at www.healthnet.com 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 by calling the number listed on the back of your ID card. . Our Customer Contact Center is available from 7:00 a.m. to 6:00 p.m., Monday through Friday, 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.

About This Booklet

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

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. 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.

Summary of Plan

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.

Please read this *Evidence of Coverage* carefully.

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**" 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 covered person, generally an Employee of a Group.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the medical group that provides or arranges for all covered services for Members. Physician Groups contracting with the Health Net Salud Network (Salud Network) provide covered services for Members in California. Sistemas Medicos Nacionales S.A. de C.V. (hereinafter referred to as SIMNSA) provides covered services 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 services 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.

Table of Contents

INTRODUCTION TO HEALTH NET **7**

How to Obtain Care **7**

Emergency and Urgently Needed Care **13**

SCHEDULE OF BENEFITS AND COPAYMENTS **17**

OUT-OF-POCKET MAXIMUM **28**

ELIGIBILITY, ENROLLMENT AND TERMINATION **30**

Who Is Eligible for Coverage **30**

Live/Work **30**

Physician/Patient Relations **30**

In Hospital on Your Effective Date **30**

Totally Disabled on Your Effective Date **30**

Late Enrollment Rule **31**

Special Reinstatement Rule For Reservists Returning From Active Duty **31**

Special Reinstatement Rule Under USERRA **31**

Transferring to Another Contracting Physician Group **31**

Effective Date of Transfer **32**

When Coverage Ends **32**

All Group Members **32**

Termination for Nonpayment of Subscription Charges **32**

Termination for Loss of Eligibility **33**

Termination for Cause **34**

How to Appeal Your Termination **34**

Coverage Options Following Termination **34**

Employer Replaces Previous Plan: **35**

When Does Cal-COBRA Continuation Coverage End? **36**

Extension of Benefits **36**

COVERED SERVICES AND SUPPLIES **38**

Medical Services and Supplies 38

Outpatient Prescription Drugs Benefits 50

Chiropractic Services and Supplies 50

Acupuncture Services 52

Mental Disorders and Chemical Dependency 53

EXCLUSIONS AND LIMITATIONS 59

General Exclusions and Limitations 59

Services and Supplies 60

GENERAL PROVISIONS 70

When the Plan Ends 70

When the Plan Changes 70

Customer Contact Center Interpreter Services 70

Members' Rights and Responsibilities Statement 70

Grievance, Appeals, Independent Medical Review, CalPERS Administrative Review and Hearing Process and Arbitration. 71

Medical Malpractice Disputes 84

Recovery of Benefits Paid by Health Net 85

Surrogacy Arrangements 86

Relationship of Parties 87

Coordination of Benefits 88

Government Coverage 93

Workers' Compensation 94

MISCELLANEOUS PROVISIONS 95

FINANCIAL INFORMATION PRIVACY NOTICE 98

NOTICE OF PRIVACY PRACTICES 99

DEFINITIONS 104

HEALTH NET SALUD PLAN SERVICE AREA 115

NOTICE OF LANGUAGE SERVICES.....117

CONTACT US 120

INTRODUCTION TO HEALTH NET

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 his or her 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 services 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 services.

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

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

Members living in California				
TYPE OF SERVICE	PHYSICIANS*	HOSPITALS*	ANCILLARY	PHARMACY
Provided in California	Your Salud Network Physician Group (which you select when you enroll)	Salud Network Hospitals	Health Net Participating providers	Pharmacy benefits are provided by OptumRx Please see your OptumRx EOC for complete benefit details
Provided in Mexico	Any SIMNSA Participating Physician	SIMNSA Hospitals	SIMNSA Participating Providers	SIMNSA Participating Pharmacy
SIMNSA Participating Pharmacy (when enrollment is allowed by the employer group)				
Members living in Mexico (when enrollment is allowed by the	PHYSICIANS*	HOSPITALS*	ANCILLARY	PHARMACY

employer group)				
Provided in California	Benefits are available only for emergency or Urgently Needed care			
Provided in Mexico	Any SIMNSA Participating Physician	SIMNSA Hospitals	SIMNSA partici-pating providers	SIMNSA Partici-pating Pharmacy

*The benefits of this plan are only available for covered services received from either a Salud Network or SIMNSA Provider, except for the following: (1) Emergency Care; (2) referrals to non-Network Providers when issued by your Salud Network or SIMNSA Physician Group; and (3) covered services 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 Care.

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

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 Enrollees

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 your Effective Date of coverage under this Plan;
- 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 non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID Card.

Selecting a Primary Care Physician

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

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

Selecting a Contracting Physician Group

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 non-emergency or non-urgent 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. Subscribers and Family Members who live in California may also obtain covered services 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 services. Such Family Members may not obtain any services in California, except in the case of Emergency Care or Urgently Needed Care.

Selecting a Participating Mental Health Professional

Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which contracts with Health Net to administer these benefits. When you need to see a Participating Mental Health Professional, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net I.D. card. The Behavioral Health Administrator will help you identify a Participating Mental Health Professional, a participating independent Physician or a subcontracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for Mental Disorders and Chemical Dependency may require prior authorization by the Behavioral Health Administrator in order to be covered. No prior authorization is required for Outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged. Please refer to the "Mental Disorders and Chemical Dependency" provision in the "Covered Services and Supplies," section for a complete description of Mental Disorders and Chemical Dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

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 Disorders and Chemical Dependency.

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 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 COVERED SERVICE.

Standing Referral to Specialty Care for Medical and Surgical Services

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

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

Changing Contracting Physician Groups Facilities

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 he or she contracts 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.

However, 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 a legitimate emergency. 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 numbers shown on your Health Net ID Card.

Timely Access to Non-Emergency Health Care Services

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

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

Definitions Related to Timely Access to Non-Emergency Health Care Services

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.

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

Scheduling Appointments with Your Primary Care Physician

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

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

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

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

Scheduling Appointments with Your Participating Mental Health Professional

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

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

- **Psychiatrist (Behavioral Health Physician) appointment:** within 10 business days of request for an appointment.
- A therapist or social worker, non-Physician appointment: within 10 business days of request for an appointment.
- **Urgent appointment for mental health visit:** within 48 hours of request for an appointment.
- Non-life threatening behavioral health emergency: within 6 hours of request for an appointment.

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

Scheduling Appointments with a Specialist for Medical and Surgical Services

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

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

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

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

Scheduling Appointments for Ancillary Services

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

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

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

Canceling or Missing Your Appointments

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

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

As a Health Net Member, when you are sick and cannot reach your doctor, like on the weekend or when the office is closed, you can call Health Net's Customer Contact Center at the number shown on your Health Net I.D. Card, and select the Triage and/or Screening option to these services. You will be connected to a health care professional (such as a doctor, nurse, or other provider, depending on your needs) who will be able to help you and answer your questions. As a Health Net Member, you have access to triage or screening service, 24 hours per day, 7 days per week.

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

Emergency and Urgently Needed Care

What to do when you need medical care immediately

In serious emergency situations: Call "**911**" or go to the nearest Hospital 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 (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or, if you cannot call them, or you need medical care right away, go to the nearest medical center or Hospital.

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 Behavioral Health Administrator 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 medical circumstances, the covered services of this Plan must be performed by your Salud Network or SIMNSA Provider or authorized by them to be performed by others. You may use other providers outside your Salud Network or SIMNSA only when you are referred to them by your Salud Network or SIMNSA Provider.

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 services from its participating providers in the United States where the Member is not permitted to enter the United States to obtain such services because he or she has 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 services 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 I.D. card. As a Health Net Member, you have access to triage or screening services, 24 hours per day, 7 days per week.

Urgently Needed Care within a 30-mile radius of your Physician Group and all Non-Emergency Care— Must be performed by your Salud Network Physician Group, or a SIMNSA Provider or be authorized by them in order to be covered.

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care (including care outside of California)— may be performed by your Physician Group or 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 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 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 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 Providers regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician Group.

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

Follow-Up Care, after your medical problem (including Severe Mental Illness and Serious Emotional Disturbances of a Child) ceases to be an emergency and your condition is stable, services must be performed or authorized by a provider within the Salud Network or SIMNSA (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or they will not be covered.

Follow-up Care after Emergency Care at a Hospital that is not contracted with the Salud Network or SIMNSA: *If you are treated for Emergency 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 (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) or it will not be covered. If, once your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and your treating Health Care Provider at the Hospital believes that you require additional Medically Necessary Hospital services, the non-contracted Hospital must contact Health Net 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 non-contracted Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your Emergency condition is stable. Also, if the non-contracted Hospital is unable to determine the contact information at Health Net or SIMNSA in order to request prior authorization, the non-contracted 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 or Urgently Needed Care is covered in California.

Definitions Related To Emergency And Urgently Needed Care

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

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 Mexico - U.S. 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 the Health Net Salud Service Area and have 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; or
- Eligible Dependents living in Mexico who live or work in Baja California within 50 miles of the U.S-Mexico border (see also the definition of "SIMNSA Service Area"), as allowed by group eligibility requirements.

If you are within this area, your Physician Group must provide or authorize all routine and Urgently Needed Care. If you are outside this area, only Emergency Care and Urgently Needed Care are covered, and your Physician Group or SIMNSA (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency) must provide or authorize all Follow-Up Care.

Prescription Drugs

For Members living in Mexico assigned to the SIMNSA network. If you purchase a covered Prescription Drug for a medical Emergency 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 services provided for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal 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 neuromuscular-skeletal 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 and Urgently Needed Care must be performed by your Physician Group or SIMNSA, or authorized by them to be performed by other Health Care Provider.

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

There are two levels of Copayments listed for each covered service or supply. 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 services 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.

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

	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 or urgent care center, the emergency room or urgent care center Copayment will not apply.

If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)

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 examination (for diagnosis or treatment, including refractive eye examinations)	$0	$0
Hearing examination (for diagnosis or treatment)	$0	$0

Note

Self-referrals are allowed for Obstetrician and Gynecological services. (Refer to the "Obstetrician and Gynecologist (OB/GYN) Self-Referral" portion 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."

Preventive Care Services

	SIMNSA	Salud Network
Preventive Care Services	$0	$0

Note

Covered services 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), breast feeding support and supplies, and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of "Covered Services and Supplies," section for details.

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

The Outpatient Prescription Drug Program is provided by OptumRx. Coverage of preventive drugs and FDA approved women's contraceptive drugs are included in OptumRx coverage with no cost sharing. Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711[TTY]) 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 Care, as defined under "Definitions", Section 900, will be covered when obtained from any licensed pharmacy, but must be obtained from a SIMNSA pharmacy if not required in conjunction with Emergency Care as defined. Refer to "Family Planning and Infertility Services" under "Covered Services and Supplies," Section 500, 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 (except for Infertility)		
Office based injectable medications (per dose)	$0	$0

Note

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

Injections for the treatment of Infertility are described below in the "Infertility Services" section.

Rehabilitation 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
Rehabilitation therapy performed in an inpatient setting	$0	$0

Note

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation Therapy" 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)	$0	$0
Physician visit to the mother or newborn at a Hospital	$0	$0
Normal delivery, including cesarean section	$0	$0
Complications of pregnancy	See note below***	See note below***
Genetic testing of fetus	$0	$0
Circumcision of newborn (birth through 30 days)****	$0	$0

Note

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 Hospital Services" headings to determine any additional Copayments that may apply.

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

***Applicable Copayment requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment will apply.

****Circumcisions for Members age 31 days and older are covered when Medically Necessary under Outpatient surgery. Refer to "Other Professional Services" and "Outpatient Hospital Services" for applicable Copayments.

Family Planning

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

Note

The diagnosis, evaluation and treatment of Infertility are described below in the “Infertility Services” section.

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 Hospital Services" headings to determine any additional Copayments that may apply.

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

Infertility Services

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

Notes

Infertility services include professional services, Inpatient and Outpatient care and treatment by injections.

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

Injections for Infertility are covered only when provided in connection with services that are covered by this Plan

If one partner does not have Health Net coverage, Infertility services are covered only for the Health Net Member.

Refer to the “Family Planning and Infertility Services” provision in the “Covered Services and Supplies,” section and the “Conception by Medical Procedures,” provision of the “Exclusions and Limitations,” section for additional information.

Other Professional Services

	SIMNSA	Salud Network
Surgery	$0	$0
Assistance at surgery	$0	$0
Administration of anesthetics	$0	$0
Chemotherapy	$0	$0
Radiation therapy	$0	$0

Laboratory and diagnostic imaging (including x-ray) services	$0	$0
Medical social services	$0	$0
Patient education	$0	$0
Nuclear medicine (use of radioactive materials)	$0	$0
Renal dialysis	$0	$0
Organ, tissue, or stem cell transplant	$0	$0

Note

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.

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
Diabetic equipment*	$0	$0
Diabetic footwear	$0	$0
Corrective Footwear (for the treatment of conditions not related to diabetes)***	Not covered	$0
Prostheses (internal or external)	$0	$0
Blood or blood products	$0	$0
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 a complete 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 for both ears and ancillary equipment every 36 months per Member. Coverage includes repair and maintenance of the hearing aid at no additional charge for a year period following the provision of a covered hearing aid. The initial hearing exam and fitting are also subject to the vision or 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.

***Corrective Footwear for the management and treatment of diabetes are covered under the “Diabetic Equipment” benefit as Medically Necessary.

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.“

Ambulance Services

	SIMNSA	Salud Network
Ground ambulance	$0	$0
Air ambulance	$0	$0

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

Note

Outpatient care for Infertility is described above in the “Infertility Services” section.

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 semiprivate 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 OptumRx. Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711 [TTY]) for complete details of prescription drug, preventive drug and women's contraceptive drug coverage.

Outpatient Prescription Drug Benefits in Mexico (by SIMNSA)

	SIMNSA	Salud Network
SIMNSA Participating Pharmacies (up to a 30 day supply in Mexico)		
Prescription Drugs dispensed through a SIMNSA Participating Pharmacy	$5	Not covered
Lancets	$0	Not covered
Oral Infertility drugs	50%	Not covered
Preventive drugs and women's contraceptives	$0	Not covered

Note:

Preventive Drugs and Women's Contraceptives:

Preventive drugs including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member 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 Disorders and Chemical Dependency Benefits

In Mexico, the Mental Disorders and Chemical Dependency benefits are administered by SIMNSA. In California, the Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which contracts with Health Net to administer these benefits.

MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH SIMNSA

Severe Mental Illness or Serious Emotional Disturbances of a Child	**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 (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day).....$0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Behavioral Health Administrator) ..... 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

Other Mental 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 (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) $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 Behavioral Health Administrator) ..... 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

Chemical Dependency 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 (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization).....$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 Behavioral Health Administrator) ..... $Not covered

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

MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH MHN SERVICES

Severe Mental Illness or Serious Emotional Disturbances of a Child — MHN SERVICES

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 (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) $0

Participating Mental Health Professional visit to Member's home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Behavioral Health Administrator) $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

Other Mental Disorders — MHN SERVICES

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 (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) $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 Behavioral Health Administrator) $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

Chemical Dependency — MHN SERVICES

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 (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) $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 Behavioral Health Administrator) $15

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

Exceptions

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

Each group therapy session requires only one half of a private office visit Copayment. In addition, each group therapy session counts as one half of a private office visit for each Member participating in the session. However, services related to Severe Mental Illness or Serious Emotional Disturbances of a Child (as defined in the "Definitions" section) are not subject to any visit (or day) limit.

Note

The applicable Copayment for Outpatient services (including intensive Outpatient care and partial hospitalization/day treatment program) is required for each visit.

MDLive Telehealth Vendor

Health Net has contracted with MDLive, a Telehealth vendor, to provide internet based medical support to CalPERS Health Net Members. Covered Services may be obtained by Contacting MDLive at 888-632-2738 or at https://www.healthnet.com/calpers.

	Copayment
MD Live Telehealth consultation	$0

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 services during a particular Calendar Year for most covered medical services and supplies of this Plan, except as described in the "Exceptions to the OOPM."

Once the total amount of all Copayments you pay for Salud Network and SIMNSA covered services and supplies under this *Evidence of Coverage* including covered services and supplies 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 services and 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 services received from a Salud Network Provider will also apply toward the OOPM for SIMNSA Provider. Any Coinsurance paid for covered services received from a SIMNSA Provider will also apply toward the OOPM for Salud Network Provider.

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 services or supplies 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 “Exclusions and Limitations,” Section for additional information.

You are required to continue to pay these Copayments listed by the bullets above after the OOPM has been reached.

How the OOPM Works

Keep a record of your payment for covered services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the Customer Contact Center at the telephone number shown on your Health Net ID Card for instructions.

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

Out-Of-Pocket Maximum

You must notify Health Net when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for payments for covered services and supplies as proof of Copayments made.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

The covered services and supplies 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 Member Account Management Division at:

CalPERS

Member Account Management Division

P.O. Box 942714

Sacramento, CA 94229-2714

Or call:

888 CalPERS (or **888**-225-7377)

(916) 795-3240 (TDD)

The covered services and supplies 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 services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that area.

Physician/Patient Relations

If the relationship between you and a Plan physician is unsatisfactory, you may call the Health Net Customer Contact Center at the telephone number on your ID Card to submit the matter to Health Net and/or request a change of Plan physician.

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 as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify 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.

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 his or her 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 Group facilities 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

If your request for a transfer is received on or before the 15th day of the month, 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 received on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 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. Concurrent with the group billing and before the subscription charges due date, a Notice of Consequences for Nonpayment of Premiums will be sent. The Notice of Consequences for Nonpayment of Premiums, will include the due date, the consequences for not paying the subscription charges by the due date, and information regarding Health net continuing to provide coverage during a 30-day grace period that begins the first day after the last day of paid coverage.

When subscription charges are not paid by the due date, a Notice of Cancellation for Nonpayment of Premiums and Grace Period is generated. The Notice will be dated and include the reason for the prospective cancellation due to non-payment of premium, effective date of the cancellation, dollar amount due to Health Net, the last day of paid coverage, the start and last day of the grace period, after which coverage will be cancelled if subscription charges are not paid. Coverage will continue during the grace period but the member is responsible for unpaid premiums and any required copayments, coinsurance or deductible amounts. The Notice of Cancellation for Nonpayment of Premiums and Grace Period will also include details of the right to request a review of the termination by the Director of the California Department of Managed Health Care and information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal.

If Health Net does not receive payment of the delinquent subscription charges from your employer within the 30-day grace period, coverage will be terminated at the end of the grace period.

If coverage through this Plan ends for reasons other than non-payment 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:

- The date established by the order; or
- 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 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 (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).

For any termination for loss of eligibility, a Notice of Cancellation, Rescission or Nonrenewal will be sent and will include: (a) the reason for and effective date of the termination; (b) details of the right to request a review of the termination by the Director of the California Department of Managed Health Care; and (c) information regarding possible eligibility for reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal.

The Subscriber and all his or her 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 I.D. 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 report criminal fraud and other illegal acts to the authorities for prosecution.

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 non-payment 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 non-payment of subscription charges, the terminated Member may be eligible for additional coverage.

Please examine your options carefully before declining 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, he or she 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 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 he or she was sent a notice from Health Net that he or she 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 his or her 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 he or she 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 he or she 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 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" or 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 he or she is or becomes 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 his or her 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.
- On the last day of the 12-month period following the date the extension began.

COVERED SERVICES AND SUPPLIES

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 service. All covered services and supplies, except for Emergency 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 to be performed by other provider.

Any covered service or supply may require a Copayment or have a benefit maximum. Please refer to the "Schedule of Benefits and Copayments" section for details.

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

Medical Services and Supplies

Ambulance Services

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

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

Please refer to the “Ambulance Services” provision of the “Exclusions and Limitations,” section for additional information.

Bariatric (Weight Loss) Surgery

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

Health Net has a specific network of 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.

Blood

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

Cardiac Rehabilitation Therapy

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

Clinical Trials

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net. The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. Services rendered as part of a clinical trial may be provided by a non-participating or participating provider subject to the reimbursement guidelines as specified in the law. Coverage for routine patient care shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health;
- The FDA as an Investigational new drug application;
- The Department of Defense; or
- The Veterans' Administration.

The following definition applies to the terms mentioned in the above provision only.

"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 a clinical trials program.

Please refer to the "General Exclusions and Limitations" portion of 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 non-emergent referral to a Specialist, you will be referred back to your Primary Care Physician for coordination of such care.

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

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

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

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 OptumRx for your pharmacy benefits. The following items would be covered through your OptumRx Pharmacy benefits.

- Blood glucose monitoring testing strips

- Lancets
- Pen needles
- Insulin syringes and needles
- Insulins
- Glucagon

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, bracing, supports, casts, nebulizers (including face masks and tubing) , peak flow meters, and spacers for the treatment for the treatment of pediatric asthma, and Hospital beds, is covered. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Member.

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

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

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

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

Family Planning and Infertility Services

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

IUDs, implantable and injectable contraceptives are covered in Mexico through SIMNSA. Prescribed contraceptives for women 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 for women are covered by OptumRx. Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711 [TTY]) for complete details of prescription drug, preventive drug and women’s contraceptive drug coverage.

Infertility services (including artificial insemination procedures, office visits, follicle ultrasounds and sperm washing) gamete intrafallopian transfer (GIFT) and supplies are covered as shown under "Infertility Services" in the "Schedule of Benefits and Copayments” section, but there are significant exclusions. Please refer to the "Conception by Medical Procedures" portion of the "Exclusions and Limitations" section.

Medically Necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment may directly or indirectly cause iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment. This benefit is subject to the applicable Copayments shown in the “Schedule of Benefits and Copayments” section, as would be required for covered services to treat any illness or condition under this Plan.

Artificial insemination is covered when a Member and/or the Member's partner is infertile (refer to Infertility in the "Definitions" section), but the services will only be covered for a Member. The collection, storage or purchase of sperm is not covered.

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

Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services are available through www.healthcare.gov. 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
- USPSTF and HRSA recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases, and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes; 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 domestic violence screening and counseling.

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the Member. 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. Breast pumps can be obtained by calling the Customer Contact Center at the phone number on your Health Net ID card.

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 OptumRx, are covered at no cost to You. Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711[TTY]) 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 non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or Outpatient services provided outside of the Member's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See the "Definitions" section. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

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.

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 benefit 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 Services include:

- Accommodations as an Inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary
- Physician services
- Specialized and critical care
- General nursing care
- Special duty nursing as Medically Necessary);
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;

- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services,
- Durable Medical Equipment and supplies;
- Medical social services
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

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 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.

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 or Investigational, 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 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.

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 contact Customer Contact Center at the telephone number on your Health Net ID Card, or 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.

Enrollees 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 Services from its participating providers in the United States where the enrollee is not permitted to enter the United States to obtain such services because he or she has 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 Services through SIMNSA participating providers in Mexico.

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 Hospital Services" in the "Schedule of Benefits and Copayments" section for more information.

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.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

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

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

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

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

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

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

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

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).

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.

In addition, prostheses to restore symmetry after a Medically Necessary mastectomy (including lumpectomy) are covered.

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.

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

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 breast.

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 in the "Exclusions and Limitations" section.

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 service unless provided by a SIMNSA provider in Mexico

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

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.

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.

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 Reassignment Surgery and Services

Gender reassignment (transgender) surgery and services related to changing a Member's physical characteristics to those of the opposite gender are covered when Medically Necessary. .

As a prerequisite to gender reassignment surgery, the candidate is required to undergo twelve (12) months of hormone therapy. This requirement will be waived if such therapy is contraindicated for clinical reasons for the surgery candidate.

Reasonable travel, lodging and meal costs, as determined by Health Net, for a Covered Person to undergo an authorized gender reassignment surgery are covered (companion not covered). Additionally, beyond the actual surgery no cosmetic procedures are covered.

If you live 50 miles or more from the nearest Health Net qualified provider in conjunction with the gender transformation treatment, 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 reassignment 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 provided 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.

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.

Outpatient Prescription Drugs Benefits

In the United States, The Outpatient Prescription Drug Program is provided by OptumRx. Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711[TTY]) 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" portion of "Exclusions and Limitations," Section 600.

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 Co-payments," Section 200.

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 an 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 conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

Second Opinion

If you would like a second opinion with regard to covered services 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 "Schedule of Benefits and Copayments," Section and obtained from an ASH Plan affiliated supplier.

Acupuncture Services

Please read the "Acupuncture Services" portion of "Exclusions and Limitations," 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 Neuromusculo-skeletal 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 includes low back Pain, post-operative Pain and post-operative dental Pain. Nausea includes adult post-operative Nausea and vomiting, chemotherapy Nausea and vomiting and Nausea of pregnancy. Neuromusculo-skeletal Disorders include musculoskeletal conditions such as fibromyalgia and myofascial Pain. Other conditions for which covered services also are available, if Medically Necessary, include carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow.

Second Opinion

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

Mental Disorders and Chemical Dependency

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

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

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

The Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which contracts with Health Net to administer these benefits. When you need to see a Participating Mental Health Professional, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net I.D. card.

Certain services and supplies for Mental Disorders and Chemical Dependency require prior authorization by the Behavioral Health Administrator 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), Outpatient detoxification, partial hospitalization, day treatment, half-day partial hospitalization and 23-hour outpatient observation);
- Inpatient, residential, partial hospitalization, inpatient ECT, inpatient psychological and neuropsychological testing and intensive Outpatient services; and
- Behavioral health treatment for Pervasive Developmental Disorder or Autism (see below under “Outpatient Services”).

No prior authorization is required for Outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

The Behavioral Health Administrator will help you identify a nearby Participating Mental Health Professional or participating independent Physician or a subcontracted provider association (IPA), 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, independent Physician or IPA will evaluate you, develop a treatment plan for you, and submit that treatment plan to the Behavioral Health Administrator for review. Upon review and authorization (if authorization is required) by the Behavioral Health Administrator or IPA, 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 the Behavioral Health Administrator to not be Medically Necessary, as defined in the “Definitions” section, services and supplies will not be covered for that condition. However, the Behavioral Health Administrator may direct you to community resources where alternative forms of assistance are available. See the “General Provisions” section for the procedure to request Independent Medical Review of a Plan denial of coverage. Medically Necessary speech, occupational and physical therapy services are covered under the terms of this Plan, regardless of whether community resources are available.

For additional information on accessing mental health services, visit our website at www.healthnet.com/calpers and select the MHN link or contact the Behavioral Health Administrator at the Health Net Customer Contact Center phone number shown on your Health Net I.D. card.

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

Transition of Care For New Enrollees

If you are receiving ongoing care for an acute, serious or chronic mental health condition from a non-Participating Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with the Behavioral Health Administrator, subject to applicable Copayments and any other exclusions and limitations of this Plan.

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

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

The following benefits are provided:

Outpatient Services

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

Covered services include:

- Outpatient office visits/professional consultation including chemical dependency: Includes outpatient crisis intervention, short-term evaluation and therapy, medication management, drug therapy monitoring, longer-term specialized therapy, and individual and group mental health evaluation and treatment.
- Outpatient services other than an office visits/professional consultation including chemical dependency: including psychological and neuropsychological testing when necessary to evaluate a Mental Disorder, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization program. Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week. Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week

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

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

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

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.

The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.

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

- Intensive Outpatient care program which is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program which is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

Second Opinion

You may request a second opinion when:

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

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

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

Any service recommended must be authorized by the Behavioral Health Administrator in order to be covered.

Inpatient Services

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered as shown in the "Schedule of Benefits and Copayments" section under "Mental Disorders and Chemical Dependency Benefits."

Covered services and supplies include:

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

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered.

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits and Copayments" section.

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

Severe Mental Illness (SMI)

Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits and Copayments" section.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder

- Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with professionally recognized standards including, but not limited to, the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as amended to date)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Other Mental Disorders

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

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

EXCLUSIONS AND LIMITATIONS

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

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the ***Evidence of Cover***age, exceed ***Evidence of Cover***age limitations or are Follow-Up Care (or related to Follow-Up Care) to ***Evidence of Coverage*** exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic Health Care Service under applicable law, or is required to be covered by other state or federal law, and is Medically Necessary as defined in the "Definitions" section.

General Exclusions and Limitations

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this *Evidence of Coverage.*

For services being rendered in Mexico, abortions are covered to the extent permitted by Mexican law

Ambulance Services

Air and ground ambulance and ambulance transport services are covered as shown in the “Ambulance Services” provision of the “Covered Services and Supplies,” section.

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

If Health Net determines that the ambulance or ambulance transport services were never performed; or

If Health Net determines that the criteria for Emergency Care were not met, unless authorized by your Physician Group, as discussed in the “Ambulance Services” provision of the “Covered Services and Supplies,” section; or

Upon findings of fraud, incorrect billings, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim;

Clinical Trials

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

- Drugs or devices that are not approved by the FDA;
- Services other than Health Care Services, including but not limited to cost of travel or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health Care Services that are specifically excluded from coverage under this *Evidence of Coverage*; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care

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

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

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

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use.

Experimental or Investigational Services

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

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section for more information; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section.

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

Home Health Care

Home Health Care is not available in Mexico.

Hospice Care

Hospice Care is only available in Mexico in an acute Hospital setting.

Ineligible Status

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

No-Charge Items

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

Personal or Comfort Items

This Plan does not cover personal or comfort items.

Unlisted Services

This Plan only covers services or supplies that are not specified as covered services or supplies in this *Evidence of Coverage,* unless coverage is required by state or federal law.

Vision Therapy, Eyeglasses and Contact Lenses

This Plan does not cover vision therapy, Eyeglasses or Contact Lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Services and Supplies

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

Aversion Therapy

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

Biofeedback

Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders such as incontinence and chronic Pain, and as otherwise preauthorized by the Behavioral Health Administrator.

Blood

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

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

Conception by Medical Procedures

Artificial insemination and gamete intrafallopian transfer (GIFT) are covered when a Member and/or the Member's partner is infertile (refer to Infertility in the "Definitions" section), but the services will only be covered for a Member. The collection, storage or purchase of sperm is not covered.

Other services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting, or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services; and
- Collection, storage or purchase of sperm or ova.
- Injections for Infertility when not provided in connection with services that are covered by this Plan.

Cosmetic Services and Supplies

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

For covered reconstructive surgery services, please refer to "Covered Services and Supplies" Section 500 under "Reconstructive Surgery."

CVS MinuteClinic Services

Services required for the treatment of Emergency Care are not covered under the CVS MinuteClinic benefit. While diabetic monitoring can be provided at a CVS MinuteClinic, care that is a continuation of treatment being provided by your Primary Care Physician or Specialist Physician is not covered under the CVS MinuteClinic benefit. Please refer to "Schedule of Benefits and Copayments," Section for applicable Copayment 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 MinuteClinics can, for example, provide a blood sugar test for diabetics, if needed.

CVS MinuteClinic Services are not available through SIMNSA.

Dental Services

Dental services or supplies are limited to the following situations:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of 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 non-covered 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, 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 seven years of age, or (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of the "Covered Services and Supplies" section).

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

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

Durable Medical Equipment

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

- 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 the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorder).
- Support appliances such as stockings, except as described in the “Prostheses” provision of "Covered Services and Supplies," Section and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the “Durable Medical Equipment” and “Diabetic Equipment” provisions of the “Covered Services and Supplies,” section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this Plan.

Fertility Preservation

Fertility preservation treatments are covered as shown in the “Family Planning and Infertility Services” provision in the “Covered Services and Supplies” section. However, the following services and supplies are not covered:

- Gamete or embryo storage
- Use of frozen gametes or embryos to achieve future conception
- Pre-implantation genetic diagnosis
- Donor eggs, sperm or embryos
- Gestational carriers (surrogates)

Genetic Testing and Diagnostic Procedures

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

Home Birth

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

Methadone Maintenance

Methadone maintenance for the purpose of long term opiate craving reduction is not covered.

Noncovered Treatments

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

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

Treatment of Delirium, Dementia, Amnesic Disorders (as defined in the DSM-IV) and Mental Retardation other than Medically Necessary Services for accompanying behavioral and/or psychological symptoms or Chemical Dependency or substance use disorder conditions only if amenable to psychotherapeutic, psychiatric, Chemical Dependency or substance use treatment, is not covered.

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

Non-eligible Institutions

This Plan only covers services or supplies provided by a legally operated Hospital, Hospice, Medicare-approved Skilled Nursing Facility or other properly licensed facility specified as covered in this *Evidence of Coverage*. Any institution that is primarily a place for the aged, a nursing home, or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.

Nonstandard Therapies

Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, hypnotherapy and crystal healing therapy are not covered.

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

Outpatient Prescription Drugs Benefits

In the United States, the Outpatient Prescription Drug Program is administered by OptumRx.

Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711[TTY]) for additional details.

Diabetic equipment and supplies for the management and treatment of diabetes are covered as Medically Necessary. Refer to “Diabetic Equipment” in “Covered Services and Supplies,” Section 500, for additional information.

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.

Physician Self-Treatment

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

Private Duty Nursing

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

Psychological Testing

Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.

Refractive Eye Surgery

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

Rehabilitation Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan contracted Physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of his or her license, to treat physical and mental health conditions, or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Coverage is subject to any required authorization from the Plan or the Member's medical group. The services must be based on a treatment plan authorized, as required by the Plan or the Member's 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 goals. See the "Definitions" section for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity

Rehabilitation therapy for physical impairments in Members with Severe Mental Illness, including, but not limited to, pervasive developmental disorder and autism, are considered Medically Necessary when criteria for rehabilitation therapy are met.

Residential Treatment Center

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

Routine Foot Care

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

Reversal of Surgical Sterilization

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

Routine Physical Examinations

This Plan does not cover routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes. A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization. See " Preventive Care Services" in the "Covered Services and Supplies" section, for information about coverage of examinations that are for preventive health purposes.

Services for Educational or Training Purposes

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). These include training for skills 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, work and, except for behavioral health treatment as indicated above in conjunction with the diagnosis of pervasive development disorder or autism.

Services Not Related To Covered Condition, Illness Or Injury

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

State Hospital Treatment

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

Surrogate Pregnancy

This Plan covers services for a surrogate pregnancy only when the surrogate is a Health Net Member. When compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision are subject to the Plan's right to recovery as described in "Recovery of Benefits Paid by Health Net Under A Surrogate Parenting Agreement" in the "Specific Provisions" section of this *Evidence of Coverage.*

Telephone Consultations

Treatment or consultations provided by telephone are not covered.

Treatment by Immediate Family Members

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

Treatment of Obesity

Treatment or surgery for obesity, weight reduction or weight control, is limited to the treatment of morbid obesity.

Treatment Related to Judicial or Administrative Proceedings

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

Unauthorized Services and Supplies

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

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

Vision Therapy, Eyeglasses and Contact Lenses

This Plan does not cover vision therapy, eyeglasses or contact lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Prescription Drugs

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

Prescription Drug benefits are only covered through SIMNSA. There is no coverage for Prescription Drugs through the Health Net Salud Network.

In the United States, the Outpatient Prescription Drug Program is administered by OptumRx.

Please refer to your OptumRx Prescription Drug Program Evidence of Coverage booklet, or call OptumRx Customer Care at 1-855-505-8110 (711[TTY]) for additional details.

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

The exclusions and limitations in the "General Exclusions and Limitations" and "Services and Supplies" portions of this section apply to Chiropractic Services.

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

Services, laboratory tests and X-rays and other treatment 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 or Investigational.

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 Providers
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 Neuromusculo-skeletal Disorders are not covered. This means that physical therapy 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

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

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

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

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

Auxiliary Aids

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

Diagnostic Radiology

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

Drugs

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

Durable Medical Equipment

Durable Medical Equipment is not covered.

Educational Programs

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

Experimental or Investigational Acupuncture Services

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

Hospital Charges

Charges for Hospital confinement and related services are not covered.

Anesthesia

Charges for anesthesia are not covered.

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

Non-Contracted Providers
Services provided 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.

X-ray and Laboratory Tests
X-ray and laboratory tests are not covered.

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 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 (the "ear cone") into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

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

General Provisions

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 non-payment, 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.

Customer Contact Center Interpreter Services

Health Net's Customer Contact Center has bilingual staff and interpreter service for additional languages to handle Member language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to your health plan in your preferred language. 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. Health Net discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If you cannot locate a Health Care Provider who meets your language needs, you can request to have an interpreter available at no charge.

Members' Rights and Responsibilities Statement

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

Members have the right to:

Receive information about Health Net, its services, its practitioners and providers and Members' rights and responsibilities;

Be treated with respect and recognition of their dignity and right to privacy;

Participate with practitioners in making decisions about their health care;

A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;

Request an interpreter at no charge to you;

Use interpreters who are not your family members or friends;

File a grievance in your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com/calpers;

File a complaint if your language needs are not met;

Voice complaints or appeals about the organization or the care it provides; and

Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility to:

Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;

Follow plans and instructions for care that they have agreed-upon on with their practitioners; and

Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

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 OptumRx. Please refer to your OptumRx Pharmacy Evidence of Coverage booklet for Pharmacy grievance procedures or you may contact OptumRx Customer Care at **1-855-505-8110** or **711** TTY.

Medical Grievance Procedures SIMNSA

Enrollees 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 enrollees 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 Identification 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 grievance involves Mental Health or Substance Abuse Services call MHN Services at **1-888-926-5108**, or write to:

MHN Services
Attention: Appeals & Grievances
P.O. Box 10697
San Rafael, CA 94912

If your concern involves Mental Health or Chemical Dependency services and you are enrolled with SIMNSA, write to:

SIMNSA
c/o International Healthcare, Inc.
303 H Street, Suite 390
Chula Vista, CA 91910
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

If your concern involves the chiropractic or acupuncture program, call the Health Net Customer Contact Center at 1-800-522-0088 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.

Health Net will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days.

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-HMO-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 Experimental or Investigational 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 Experimental or Investigational 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 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.

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 Health Net, you should first telephone Health Net toll free 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, an appeal that has not been satisfactorily resolved by your health plan, or an appeal that has remained unresolved for more than 30 days, you may call DMHC for assistance.

You may also be eligible for an 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. DMHC also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. DMHC's Internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and online instructions.

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 Member Account Management Division
Attn: Enrollment Administration
P.O. Box 942714
Sacramento, CA 94229-2714

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)

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. 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.

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 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.

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 arbitration's under this process. In the event that the total amount of damages claimed is $200,000 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 $200,000. In the event that total amount of damages is over $200,000, 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: Litigation Administrator

PO Box 4504

Woodland Hills, CA 91365-4505

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 Litigation Administrator 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.

The request must be mailed to:
CalPERS Health Plan Administration Division
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 30 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.

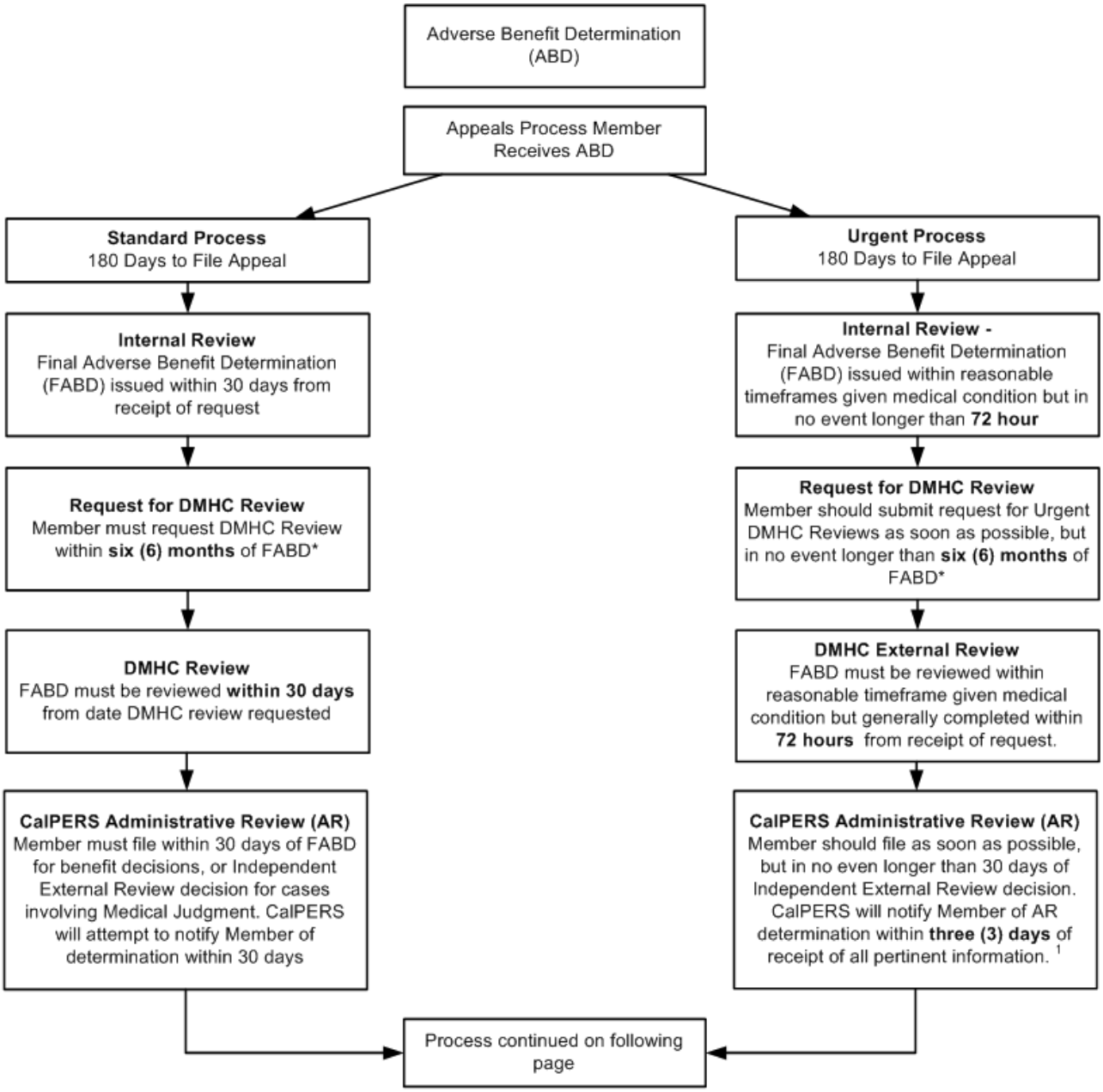
Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally**. you may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.

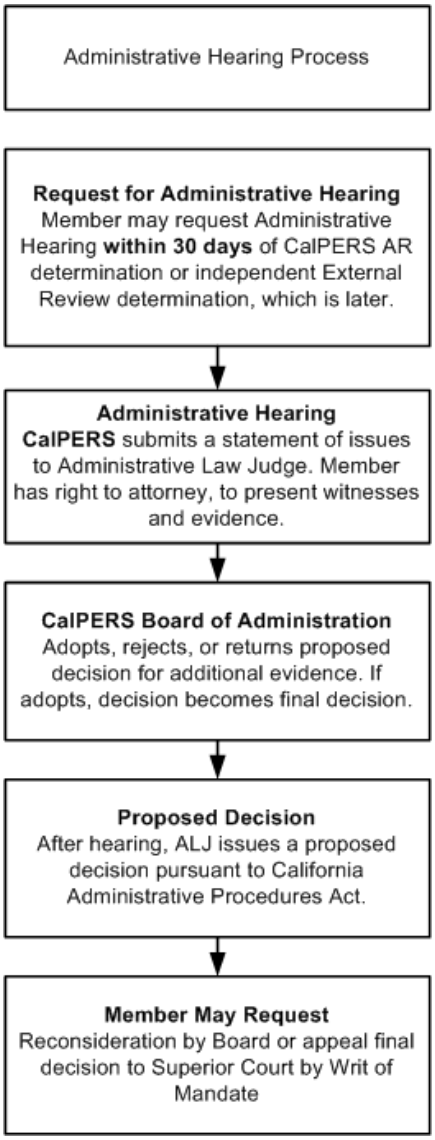
- **Records subject to attorney-client privilege**. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.

- **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 his or her 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 Experimental, Investigational, 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, his or her office staff, the contracting Physician Group or Health Net personnel.
- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or 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 or Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational or Experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

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

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

Medical Malpractice Disputes

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

Recovery of Benefits Paid by Health Net

WHEN YOU ARE INJURED

If you are ever injured through the actions of another person or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries Health Net, 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 services provided by the Plan and you specifically direct such medical payments carriers to directly reimburse the Plan on your behalf.

STEPS YOU MUST TAKE

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

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;

- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan; and
- Hold any money that you or your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

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

Assignment of Your Surrogacy Payments

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

Duty to Cooperate

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

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

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

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

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

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

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 services or supplies 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 services and supplies of this Plan.

Provider/Patient Relationship

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

Liability for Charges

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

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

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

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);
- 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.

If you would like more information on how to request continued care or request a copy of our continuity of care policy, please contact the Customer Contact Center at the telephone number on your Health Net ID Card.

Contracting Administrators

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

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this *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 determine 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 do 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 non-governmental 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 covered person 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 covered person does not comply with the Plan provisions is not an Allowable Expense.

Examples of these provisions are second surgical opinions, precertification 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 covered persons 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 his or her Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her 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 (non-dependent), 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 covered person 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 covered person is enrolled in two or more closed Panel Plans and if, for any reason, including the person's having received services from a non-panel 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 non-panel 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 covered person.

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. 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 Services 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 Services 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

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 services 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 services and supplies 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 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 or Urgently Needed Care from a non-Health Net provider), you must do so within 90 days 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 to obtain claim forms.

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

Health Net Commercial Claims

P.O. Box 14702

Lexington, KY 40512

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.

If you need to file a claim for Emergency Mental Disorders and Chemical Dependency, or for other covered Mental Disorders and Chemical Dependency Services provided upon referral by the Behavioral Health Administrator, MHN Services, you must file the claim with MHN Services within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that it was not reasonably possible to file the claim within one year, and that is was filed as soon as reasonably possible. You must use the CMS (HCFA) – 1500 in filing the claim and you should send the claim to MHN Services at the address listed in the claim form or to MHN Services at:

MHN Services

P.O. Box 14621

Lexington, KY 40512-4621

MHN Services will give you claim forms on request. For more information regarding claims for covered Mental Disorders and Chemical Dependency Services, you may call MHN Services at 1-800-444-4281 or you may write MHN Services at the address given immediately above.

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 services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgently Needed Care" section under 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.

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.

FINANCIAL INFORMATION PRIVACY NOTICE

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

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or contact Health Net at 1-800-522-0088.

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.

This Notice tells you about the ways in which Health Net and the Behavioral Health Administrator (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" 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.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the notice. This will include, but may not be limited to updating the Notices available on our website, www.healthnet.com. (Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.)

How We May Use And Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

Payment. We use and disclose your protected health information in order to pay for your covered health coverage or expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.

Health Care Operations. We use and disclose your protected health information in order to perform our Plan activities, such as quality assessment activities or administrative activities, including data management or customer service.

Treatment. We may use and disclose your protected health information to assist your Health Care Providers (doctors, pharmacies, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

Plan Sponsor. 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.

Person(s) Involved in Your Care or Payment for Your Care. We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

***This Notice of Privacy Practices also applies to enrollees in any of the following** Health Net Access, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

Other Permitted Or Required Disclosures

As Required by Law. We must disclose protected health information about you when required to do so by law.

Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g. California Department of Health Services) for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its 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.

Other Uses Or Disclosures that Require Your Written Authorization

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

- **Marketing.** We will request your written authorization to use or disclose your protected health information 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.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.
- **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.

***This Notice of Privacy Practices also applies to enrollees in any of the following** Health Net Access, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information contained in a designated record set, with some limited exceptions. You may request that we provide copies of this protected health information in a format other than photocopies, such as providing them to you electronically, if it is readily producible in such form and format. Usually the protected health information contained in a designated record set includes enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of this protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing or sending electronically your requested information, but we will tell you the cost in advance. If we deny your request for access, 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 Protected Health Information. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records or you ask to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

*__This Notice of Privacy Practices also applies to enrollees in any of the following__ Health Net Access, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request*. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information or both; and (3) to whom you want the restrictions to apply.

Right To Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Notice in the Event of a Breach. You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.

Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes To This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com/calpers. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new Effective Date.

Privacy Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Contact The Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, you may send it in writing to:

Address:

Health Net Privacy Office

Attention: Privacy Officer

P.O. Box 9103

***This Notice of Privacy Practices also applies to enrollees in any of the following** Health Net Access, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-888-926-4921

Fax: 1-818-676-8314

Email: Privacy@healthnet.com

Contact information for the Department of Health and Human Services:

Address: Department of Health and Human Services

Attention: Secretary of the Department of Health and Human Services

1600 Ninth Street, room 460

Sacramento, CA 95814

*Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.

*__This Notice of Privacy Practices also applies to enrollees in any of the following__ Health Net Access, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

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 Neuromusculo-skeletal 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 Conditions is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the Acute Condition.

American Specialty Health Plans of California, Inc. (ASH Plans) is a specialized health care service plan contracting with Health Net to arrange the delivery of Chiropractic and Acupuncture Services through a network of Contracted Chiropractors and Contracted Acupuncturist.

Behavioral Health Administrator is an affiliate behavioral health services administrator which contracts with Health Net or SIMNSA to administer delivery of Mental Disorders and Chemical Dependency services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities. Health Net has contracted with MHN Services to be the Behavioral Health Administrator for Members residing in California. Services received for Members in Mexico must be provided by a SIMNSA mental health participating provider.

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.

Chemical Dependency is alcoholism, drug addiction, or other Chemical Dependency problems.

Chemical Dependency Care Facility is a Hospital, Residential Treatment Center, structured Outpatient program, day treatment or partial hospitalization program, or other mental health care facility that is licensed to provide Chemical Dependency detoxification services or rehabilitation services.

Chiropractic Appliances are support type devices prescribed by a Contracted Chiropractor specifically for the treatment of a Neuromusculo-skeletal 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 Neuromusculo-skeletal Disorders and Pain syndromes. These services are limited to the management of Neuromusculo-skeletal 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 services. The Copayment for each covered service 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.

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 non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. CVS MinuteClinics also offer the administration of certain vaccines or immunizations such as tetanus or hepatitis; however, they are not designed to be an alternative for emergency services or the ongoing care provided by a Physician.

CVS MinuteClinics must be licensed and certified as required by any state or federal law or regulation, must be staffed by licensed practitioners, and have a Physician on call at all times who also sets protocols for clinical policies, guidelines and decisions.

CVS MinuteClinic healthcare services in the State of California are provided by MinuteClinic Diagnostic Medical Group of California, Inc.

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.

Emergency Acupuncture Services are covered services that are Acupuncture Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculo-skeletal 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 Care includes medical screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, either within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute Hospital or to an acute psychiatric Hospital as Medically Necessary.

Emergency Care includes air and ground ambulance and ambulance transport services provided through the **"911"** emergency response system. Health Net or SIMNSA, will make final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Emergency Chiropractic Services are covered services that are Chiropractic Services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculo-skeletal 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 is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an Emergency Medical Condition. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Member or unborn child.

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) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

With regard to Chiropractic Services and Acupuncture Services, "Experimental" services are chiropractic care or acupuncture care that is an unproven Chiropractic Service or Acupuncture Service that does not meet professionally recognized, valid, evidence-based standards of practice.

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

Family Members are Dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness, or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

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 the kinds of providers other than M.D.s or D.O.s, that take care of your health and are covered under this plan. The provider must:

- Have a license to practice where the care is given.
- Provide a service covered by that license.
- Give you a service that is paid for under this plan.

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 his/her 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 his or her place of residence that is prescribed by the Member's attending Physician as part of a written plan**.** Home Health Care Services are covered if the Member is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified Physician who oversees patient care and is designed to achieve Physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare 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) is a process where expert independent medical professionals are selected to review decisions made by the health care service plan. An IMR can be requested through the Department of Managed Health Care

Infertility exists when any of the following apply to a Member when the Member or the Member's partner who has not yet gone through menopause:

The Member has had coitus on a recurring basis for one year or more without use of contraception or other birth control methods and has not become pregnant, which has not resulted in a pregnancy, or when a pregnancy did occur, a live birth was not achieved; or;

The Member has been unable to achieve conception after six cycles of artificial insemination; or

The Physician has diagnosed a medical condition that prevents conception or live birth.

Infertility exists when a Physician has diagnosed a medical condition that prevents conception or live birth.

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 approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net or SIMNSA will decide whether a service or supply is Investigational.

With regard to Chiropractic Services and Acupuncture Services, "Investigational" services are chiropractic care or acupuncture care that is investigatory.

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

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

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

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

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Employee, annuitant or a family member who is eligible and enrolled under this Evidence of Coverage, and for whom we have received applicable premiums.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group or SIMNSA.

Mental Disorders is a nervous or mental condition that meets all of the following conditions:

It is a clinically significant behavioral or psychological syndrome or pattern;

It is associated with a painful symptom, such as distress;

It impairs a patient's ability to function in one or more major life activities; or

It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

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.

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 month 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 Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. Copayments, which are paid toward certain covered services, 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 Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an Outpatient basis. It must be licensed as an Outpatient clinic according to state and local laws and must meet all requirements of an Outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain, and post-operative dental Pain.

Participating Behavioral Health Facility is a Hospital, Residential Treatment Center, structured Outpatient program, day treatment, partial hospitalization program, or other mental health care facility that has signed a service contract with Health Net, to provide Mental Disorder benefits and Chemical Dependency rehabilitation services.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, or Chemical Dependency 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. The Participating Mental Health Professional must have a service contract with Health Net to provide Mental Disorder services and Chemical Dependency 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 services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these 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 non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Psychiatric Emergency Medical Condition means a Mental Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

An immediate danger to himself or herself or to others.

Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, 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, entity, or group that 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 employ and 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 is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and is approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider, and who meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

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 contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances of a Child exist when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date, other than a primary Chemical Dependency disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year;

The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or

The child meets special education eligibility requirements under Chapter 26.5 (commencing with section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders,* as amended to date*)*, autism, anorexia nervosa and bulimia nervosa.

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 Inpatients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Specialty Drugs are identified in the Health Net Recommended Drug List because they have at least one of the following features:

Treatment of a chronic or complex disease

Require high level of patient monitoring, or support

Require specialty handling, administration, unique inventory storage, management and/or distribution

Require specialized patient training

Are subject to limited distribution

Specialty Drugs may be given orally, topically, by inhalation, or by self-injection (either subcutaneously or intramuscularly). A list of Specialty Drugs can be found in the Health Net Recommended Drug List on our website at healthnet.com or by calling the Customer Contact Center telephone number listed on your Health Net ID card.

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.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a Terminal Illness.

Transplant Performance Center is a provider in Health Net's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and Follow-Up Care. For purposes of determining coverage for transplants and transplant-related services, Health Net's network of Transplant Performance Centers includes any providers in Health Net's designated supplemental resource network.

Urgently Needed Care includes otherwise covered medical service a person would seek for treatment of an injury unexpected illness, or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

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:

91310	91355	91384	93532	93539	93553	93591
91321	91377	91385	93534	93543	93563	93599
91322	91380	91386	93535	93544	93584	
91350	91381	91387	93536	93550	93585	
91351	91382	91390	93537	93551	93586	
91354	91383	93510	93538	93552	93590	

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	92004
91906	92036
91934	92066
91962	92086
91963	
91380	

Orange County

You must live or work in Orange County.

San Bernardino County

You must live or work in the following zip codes:

91701	91759	92317	92336	92359	92391	92410
91708	91761	92318	92337	92369	92399	92411
91709	91762	92321	92344	92373	92401	92412
91710	91763	92322	92345	92374	92402	92413
91729	91764	92324	92346	92375	92403	92414
91730	91784	92325	92350	92376	92404	92415
91737	91786	92326	92352	92377	92405	92418
91739	91798	92331	92354	92378	92406	92423
91743	92313	92334	92357	92382	92407	92424
91758	92316	92335	92358	92385	92408	92427

Riverside County

You must live or work in the following zip codes:

91752	92501	92507	92516	92551	92557	92878
91766	92502	92508	92517	92552	92570	92879
92320	92503	92509	92518	92553	92571	92880

92324	92504	92313	92519	92554	92599	92881
92373	92505	92514	92521	92555	92860	92882
92329	92506	92515	92522	92556	92877	92883

Kern County

CVS MinuteClinic is not available in Kern County. You must live or work in the following zip codes:

93217	93303	93308	93314
93263	93304	93309	
93300	93305	93311	
93301	93306	93312	
93302	93307	93313	

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.

NOTICE OF LANGUAGE SERVICES

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 us at the number listed on your ID card or Individual and Family members please call 800-839-2172. Employer group members please call 800-522-0088. Healthy Families members please call 888-231-9473.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación, o si es afiliado Individual o Familiar llame al 800-839-2172. Los afiliados del grupo de empleadores deben llamar al 800-522-0088. Los afiliados de Healthy Families deben llamar al 888-231-9473.
Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡上所列的電話號碼，個人與家庭計畫會員請撥 800-839-2172。僱主團體會員請撥 800-522-0088。健康家庭計畫會員請撥 888-231-9473。
Chinese

Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được thông dịch viên trợ giúp và được đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc các hội viên diện Cá Nhân hoặc Gia Đình xin gọi số 800-839-2172. Các hội viên tham gia chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên Healthy Families xin gọi số 888-231-9473.
Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드 상의 안내번호로 전화해 주시거나, 개인 및 가족 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. Healthy Families 회원께서는 안내번호 888-231-9473번을 이용하십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa Healthy Families members, mangyaring tumawag sa 888-231-9473.
Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե Անհատական և Ընտանեկան անդամ եք, խնդրում ենք զանգահարել 800-839-2172 համարով: Գործատիրոջ Խմբի անդամներից խնդրվում է զանգահարել 800-522-0088 համարով: Healthy Families-ի անդամներից խնդրվում է զանգահարել 888-231-9473 համարով:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники планов индивидуального или семейного страхования могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники плана Здоровые семьи (Healthy Families) могут позвонить по телефону 888-231-9473.
Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人・家族会員の方は、800-839-2172まで、雇用者団体会員の方は、800-522-0088まで、また、Healthy Families 会員の方は、888-231-9473までご連絡ください。
Japanese

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 us at the number on your ID card. For Individual and Family or Farm Bureau members please call 800-839-2172. Employer group members please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: for more help call the Department of Managed Health Care HMO Help Line at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación. Para los afiliados de Individual y Familiar o de la Oficina Agrícola, llame al número 800-839-2172. Los afiliados de un grupo del empleador deben llamar al 800-522-0088. Afiliados de PPO: para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados de HMO: para obtener más ayuda llame a la Línea de Ayuda del Departamento de Cuidado Médico de HMO al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。欲取得協助，請撥打您會員卡上的電話號碼與我們聯絡。個人與家庭計畫或農業協會的會員請撥打 800-839-2172。僱主團體會員請撥打 800-522-0088。PPO 會員：欲取得更多協助，請致電加州保險局 1-800-927-4357。HMO 會員：欲取得更多協助，請致電醫療保健計畫管理局 HMO 協助專線 1-888-HMO-2219。 **Chinese**

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Các hội viên Individual and Family hoặc Farm Bureau có thể gọi số 800-839-2172. Các hội viên trong chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên PPO: để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Các hội viên HMO: để được giúp đỡ thêm, xin gọi Đường Dây Trợ Giúp HMO của Sở Điều Quản Y Tế tại số 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드상의 안내번호로 전화해 주십시오. 개인 및 가족 회원 혹은 Farm Bureau 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. PPO 가입자: 보다 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: 보다 많은 도움이 필요하신 분은 보건관리부 (the Department of Managed Health Care)의 HMO 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: para sa karagdagang tulong, tumawag sa Department of Managed Health Care HMO Help Line sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեր լեզվով: Օգնության համար, մեզ զանգահարեք ձեր ինքնության տոմսի վրա նշված համարով: Եթե անդամ եք Անհատական և Ընտանեկան կամ Ագարակային Գրասենյակի (Farm Bureau), զանգահարեք 800-839-2172 համարով: Գործատիրոջ խմբի անդամներից խնդրվում է զանգահարել 800-522-0088 համարով: PPO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: HMO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-888-HMO-2219 համարով զանգահարեք Կառավարված Առողջական Խնամքի Օգնության Գծին: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте; участники планов индивидуального или семейного страхования, а также планов страхования Фермерского бюро могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники системы предпочтительного выбора (Preferred Provider Organization, PPO): для получения дополнительной помощи звоните в Министерство страхования штата Калифорния по телефону 1-800-927-4357. Участники организаций медицинского обслуживания (Health Maintenance Organizations, HMO): для получения дополнительной помощи звоните в справочную службу HMO Департамента организованного медицинского обслуживания по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人、家族会員、または、ファーム・ビューロー会員の方は、800-839-2172 まで、雇用者団体会員の方は、800-522-0088 までご連絡ください。PPO会員の方：更なるお問い合わせは、カリフォルニア州保険庁、 1-800-927-4357 までご連絡ください。HMO会員の方：更なるお問い合わせは、カリフォルニア州管理医療庁のHMO相談窓口、 1-888-466-2219 までご連絡ください。 **Japanese**

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم، شفاهی برخوردار شده و بگویند مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. اعضاء «طرح افراد و خانواده ها» یا «طرح مزارع» لطفاً به شماره 800-839-2172 تلفن کنند. اعضاء گروههای کارفرمایان لطفاً با شماره 800-522-0088 تماس بگیرند. اعضاء PPO: برای کسب اطلاعات بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO: برای کسب اطلاعات بیشتر به خط کمکی HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-839-2172 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ ਦੀ HMO ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការកម្រៃភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកកាត់ប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរក្នុង។ សំរាប់ជំនួយ សូមទូរស័ព្ទអាងយោងនៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។ សំរាប់សមាជិក យុវជិតគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172។ សមាជិកក្រុមហ៊ុនស៊ីប្រាក់ឈ្នួល សូមទូរស័ព្ទបកលេខ 800-522-0088។ សមាជិក PPO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាลิហ្វ៉ូร์ញ៉ា តាមលេខ 1-800-927-4357។ សមាជិក HMO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងគ្រប់គ្រងសុខាភិបាល ខ្សែជួយជំនួយ HMO តាមលេខ 1-888-HMO-2219។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الاستعانة بمترجم. يمكنك طلب قراءة وثائق وإرسال بعضها لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). بالنسبة للأفراد وأعضاء الأسرة أو أعضاء Farm Bureau رجاء الاتصال بالرقم 800-839-2172. وبالنسبة لأعضاء مجموعات صاحب العمل رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية، يرجى الاتصال بالمجلد الخاص بإدارة التأمين الصحي لولاية كاليفورنيا على الرقم 1-800-927-4357. أعضاء HMO: للحصول على المساعدات الإضافية يرجى الاتصال بخط المساعدة لـ Department of Managed Health Care على الرقم 1-888-HMO-2219. **Arabic**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj kom muaj ib tug neeg txhais lus rau koj los tau. Koj kom nyeem cov ntaub ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj los tau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Rau cov tswv cuab hauv pawg Tus Kheej thiab Tsev Neeg los sis Farm Bureau thov hu rau 800-839-2172. Cov tswv cuab hauv pawg tom chaw ua haujlwm thov hu rau 800-522-0088. Cov tswv cuab hauv PPO: yog xav tau kev pab ntxiv hu rau CA Lub Koom Haum Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov tswv cuab hauv HMO: yog xav tau kev pab ntxiv hu rau Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບຸກຄົນແລະຄອບຄົວ ຫລືສະມາຊິກ Farm Bureau ໂທຕາມໝາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກກຸ່ມລູກຈ້າງໂທຕາມໝາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍນີເຍຕາມໝາຍເລກ 1-800-927-4357. ສະມາຊິກ HMO: ເພື່ອຈະໄດ້ຮັບຄວາມຊວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທຕາມສາຍດວນ HMO ແຫ່ງກົມກາໍກັບລະບົບຄຸ້ມຄອງການຮັກສາສຸຂະພາບ (Department of Managed Health Care) ຕາມໝາຍເລກ 1-888-HMO-2219. **Laotian**

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)

Telecommunications Device for
the Hearing and Speech Impaired
1-888-926-5003

www.healthnet.com/calpers

Health Net of California, Inc. is a subsidiary of Health Net, Inc.
Health Net® is a registered service mark of Health Net, Inc. All rights reserved.