

EVIDENCE OF COVERAGE AND PLAN DOCUMENT

An explanation of your plan

HMO (Plan 8H1) 298652

Important benefit information – please read



Dear Health Net Member:

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

If your employer has so designated, you can choose to access this document online through Health Net's secure website at www.healthnet.com. You can also elect to have a hard copy of this *Evidence of Coverage* mailed to you by calling the Member Services Department at 1-800-522-0088.

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 Member Services Department at the telephone number on your Health Net ID Card, your Physician Group 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 "Definitions," Section 900.

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**" and "**Eligible Employee**" have 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 the individual Member selected as the source of all covered medical care.
- "**Primary Care Physician**" is the individual Physician each Member selected who will provide or authorize all covered medical care.
- "**Group**" is the business entity (usually an employer or Trust) that contracts with Health Net to provide this coverage to you.
- "**Plan**" and "**EOC**" have similar meanings. You may think of these as meaning your Health Net benefits.

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Section-100

INTRODUCTION TO HEALTH NET

Subsection-A

How to Obtain Care

When you enroll in this Plan, you must select a contracting Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. For contact information on your Physician Group, please call the Member Services Department at the telephone number on your Health Net ID card.

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 the Member Services Department at 1-800-522-0088 to ensure that you can obtain the health care services that you need.

If You Are Enrolled In An Employer Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some employer plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact your Employer to determine if You are enrolled in a Plan that is subject to ERISA.

Transition of Care For New Enrollees

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

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

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 900.

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 Member Services Department at the telephone number on your Health Net ID Card.

Selecting a Contracting Physician Group

Family Members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. If you reside outside the Health Net Service Area, then you may enroll based on the Subscriber's work address that is within the Health Net Service Area. Family Members who reside outside the Health Net Service Area may also enroll based on the Subscriber's work address that is within the Health Net 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. Please call the Member Services Department at the number shown on your Health Net ID Card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.healthnet.com.

Selecting a Primary Care Physician

In addition to selecting a contracting Physician Group, you must choose a Primary Care Physician at the contracting Physician Group. A Primary Care Physician provides and coordinates your medical care.

Specialists and Referral Care

Sometimes, you may need care that the Primary Care Physician cannot provide. At such times, you will be referred to a Specialist or other health care provider for that care.

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

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 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.

Changing Contracting Physician Groups

You may transfer to another contracting Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 400.

Your Financial Responsibility

Your Physician Group 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 "Schedule of Benefits and Copayments," Section 200. Providing funds are available, you can use your HRA account funds to pay any required Copayments or coinsurance for eligible health care expenses incurred by you or your covered dependents.

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

Questions

Call the Member Services Department with questions about this Plan at the number shown on your Health Net ID Card.

Subsection-B

Emergency and Urgently Needed Care

Health Net uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. Health Net applies the prudent layperson standard to evaluate the necessity of medical services which a Member accesses in connection with a condition that the Member perceives to be an emergency situation. Please refer to "Emergency Care" in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care." Please refer to the following information for a description of how to access your emergency benefits. Additional information is also located in the "Schedule of Benefits and Copayments" section.

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

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

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

If you are unsure of whether an emergency medical condition exists, you may call your Physician Group or Primary Care Physician for assistance.

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

Except in an emergency or other urgent medical circumstances, the covered services of this Plan must be performed by your Physician Group or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group.

Urgently Needed Care within a 30-mile radius of your Physician Group and all Non-Emergency Care must be performed by your Physician Group or authorized by them in order to be covered. These services, if performed by others outside your Physician Group, will not be covered unless they are authorized by your Physician Group.

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

It is critical that you contact your Physician Group as soon as you can after receiving emergency services from others outside your Physician Group. Your Physician Group will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care. They will also advise you about how to obtain reimbursement for charges you may have paid.

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

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

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

Follow-up Care after Emergency Care at a Hospital that is not contracted with Health Net: *If you are treated for Emergency Care at a Hospital that is not contracted with Health Net, Follow-up Care must be authorized by Health Net or it will not be covered. If, once your Emergency medical condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital services, the non-contracted Hospital must contact Health Net to obtain timely authorization. If Health Net*

determines that you may be safely transferred to a Hospital that is contracted with Health Net and you refuse to consent to the transfer, the non-contracted Hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your Emergency condition is stable. Also, if the non-contracted Hospital is unable to determine the contact information at Health Net in order to request prior authorization, the non-contracted Hospital may bill you for such services.

Definitions Related To Emergency And Urgently Needed Care

The following terms are located in "Definitions," Section 900, but they are being repeated here for your convenience.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child) and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance, and ambulance transport services provided through the **911** emergency response system.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate such condition, either within the capability of the facility or by transferring the Member to another facility as Medically Necessary to treat the Psychiatric Emergency Medical Condition.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine 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 reasonably have known an emergency did not exist.

Subsection-C

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 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 reasonable layperson, with no special knowledge of health or medicine or chiropractic, could reasonably expect that a delay of immediate attention could result in any of the following:

- 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;

- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Decrease the likelihood of maximum recovery.

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.

Section-200

SCHEDULE OF BENEFITS AND COPAYMENTS

The following schedule shows the Copayments that you must pay for this Plan's covered services and supplies.

Percentages shown below may be referred to as "coinsurance" and are applied to amounts agreed to in advance by Health Net and the Member's Physician Group or other health care provider.

You must pay the stated Copayments when you receive the services.

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to "Out-of-Pocket Maximum," Section 300, for more information.

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

	<u>Copayment</u>
Use of emergency room (facility and professional services)	\$35
Use of urgent care center (facility and professional services)	\$35

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

	<u>Copayment</u>
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group	\$15
Specialist consultation.....	\$15
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net).....	\$30
Periodic health evaluation (includes annual preventive physical examinations)	\$15
Hearing examination	\$15

Note

Self-referrals are allowed for Obstetrician and Gynecological services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" portion of "Covered Services and Supplies," Section 500.)

Hospital Visits by Physician

	<u>Copayment</u>
Physician visit to Hospital or Skilled Nursing Facility	\$0

Allergy, Immunizations and Injections

	<u>Copayment</u>
Allergy testing	\$0
Allergy injection services	\$0
Allergy serum.....	\$0
Immunizations for occupational purposes or foreign travel.....	20%
Other immunizations	\$0
Injections for Infertility	50%
All other injections	

COPAYMENTS

Office based injectable medications (per dose)	\$0
Self-injectable drugs	\$0

Note

Injections for Infertility are covered only when provided in connection with services that are covered by this Plan. (Refer to "Conception by Medical Procedures," portion of "Exclusions and Limitations," Section 600.)

Rehabilitation Therapy

Copayment

Physical therapy	\$0
Occupational therapy	\$0
Speech therapy	\$0
Pulmonary rehabilitation therapy	\$0
Cardiac rehabilitation therapy	\$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" of "Exclusions and Limitations," Section 600.

Care for Conditions of Pregnancy

Copayment

Prenatal or postnatal office visit	\$15
Newborn care office visit (birth through 30 days)	\$15
Physician visit to the mother or newborn at a Hospital	\$0
Normal delivery, including cesarean section	\$0
Complications of pregnancy, including Medically Necessary abortions	\$0
Elective abortion	\$150
Genetic testing of fetus	\$0
Circumcision of newborn (birth through 30 days) ***	\$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 "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may 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

Copayment

Infertility services (all covered services that diagnose, evaluate or treat Infertility)	50%
Sterilization of female	\$150
Sterilization of male	\$50
Injectable contraceptives (including but not limited to Depo Provera)	\$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.

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

COPAYMENTS

Other Professional Services

Copayment

Surgery	\$0
Assistance at surgery	\$0
Administration of anesthetics.....	\$0
Chemotherapy	\$0
Radiation therapy.....	\$0
Laboratory and diagnostic imaging (including x-ray) services.....	\$0
Medical social services.....	\$0
Patient education	\$0
Nuclear medicine (use of radioactive materials).....	\$0
Renal dialysis.....	\$0
Organ, tissue, or stem cell transplants.....	\$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

Copayment

Durable Medical Equipment, nebulizers including face masks and tubing	\$0
Orthotics (such as bracing, supports and casts)	\$0
Diabetic equipment*	\$0
Diabetic footwear	\$0
Prostheses (internal or external).....	\$0
Blood or blood products	\$0

Notes

* For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in "Covered Services and Supplies," Section 500.

Home Health Care Services

Copayment

Copayments are required for home health visits on and after the 31 st calendar day of the treatment plan.....	\$15
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Hospice Services

Copayment

Hospice care.....	\$0
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Ambulance Services

Copayment

Ground ambulance.....	\$0
Air ambulance.....	\$0

COPYMENTS

Inpatient Hospital Services

Copayment

Room and board in a semi-private room or special care unit including ancillary (additional) services.....	\$0
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Exception

The Copayment for a Hospital confinement for Infertility services is 50%.

Outpatient Hospital Services

Copayment

Outpatient facility services (other than surgery)	\$0
Outpatient surgery (surgery performed in a Hospital or Outpatient Surgical Center only)	\$0

Note

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.

Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the Copayment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a Hospital or Outpatient Surgical Center, a therapeutic (surgical) procedure is performed, then the Copayment applicable for outpatient surgery will be required instead of the Copayment 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

Copayment

Room and board in a semi-private room with ancillary (additional) services	\$0
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Limitation

Skilled Nursing Facility services are covered for up to a maximum of 100 days a Calendar Year for each Member.

Chiropractic Services and Supplies

Office Visits

Copayment

New patient examination	\$5
Each subsequent visit	\$5
Re-examination visit.....	\$5
Second opinion	\$5

Note

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

Limitations

Up to 40 Medically Necessary office visits to a Contracted Chiropractor during a Calendar Year are covered.

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

COPAYMENTS

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.

Eyewear Benefits

Eye examinations to determine the need for correction of vision are not covered. Vision Care is covered through a direct contract between County of Sacramento and Vision Service Plan. Please refer to your Vision Service Plan Summary Plan Description for benefits or contact them Vision Service Plan at **1-800-877-7195**.

Mental Disorders and Chemical Dependency Benefits

Copayments for covered services provided for the treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child are the same as the Copayments required for the services when provided for a medical condition.

Severe Mental Illness or Serious Emotional Disturbances of a Child **Copayment**

Outpatient consultation (psychological evaluation or therapeutic session in an office setting)	\$15
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	\$0
Inpatient services	\$0
Intensive outpatient care or partial hospitalization/day treatment.....	\$0

Other Mental Disorders **Copayment**

Outpatient consultation (psychological evaluation or therapeutic session in an office setting) (20 visit maximum each Calendar Year)	\$30
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	\$0
Inpatient services (30 day maximum each Calendar Year)	\$0
Intensive outpatient care or partial hospitalization/day treatment (20 visit maximum each Calendar Year)	\$0

Chemical Dependency **Copayment**

Outpatient consultation (psychological evaluation or therapeutic session in an office setting) (20 visit maximum each Calendar Year)	\$30
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	\$0
Inpatient services (30 day maximum each Calendar Year)	\$0
Intensive outpatient care or partial hospitalization/day treatment (20 visit maximum each Calendar Year)	\$0
Detoxification	\$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 "Definitions," Section 900) are not subject to any visit (or day) limit.

Note

The applicable Copayment for outpatient services is required for each visit.
 The above inpatient services Copayment is applicable for each admission.

Section-300

OUT-OF-POCKET MAXIMUM

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

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

The OOPM amounts for this Plan are:

- One Member..... \$1500
- Two Members..... \$3000
- Family (three or more Members) \$4500

Exceptions 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 or expenses paid by you for covered services or supplies under this Plan will not be applied to the OOPM amount:

- Copayments made for chiropractic benefits.
- Copayments or expenses paid for services that diagnose, evaluate or treat infertility.

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 medical services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the Member Services Department at the telephone number shown on your Health Net ID Card for instructions.

- If an individual Member pays amounts for covered services 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 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 for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net, and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the Family OOPM.

You 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 as proof of Copayments made.

Section-400

ELIGIBILITY, ENROLLMENT AND TERMINATION

Subsection-A

Who Is Eligible for Coverage

1. Subscriber: The principal Member (employee).Eligible Employee:
 - a. An "Eligible Employee" is defined as 1) a regular employee who is working full-time or part-time for the County; 2) an elected official and his or her exempt deputy or assistant; or 3) any regular employee who temporarily transfers to a temporary position. A regular employee for purposes of this Plan means any officer or employee, in civil service or not in civil service, who occupies a permanent position, whether part-time or full-time, established in accordance with the annual salary ordinance, in the class which is intended for permanent or career-type employment.
 - b. An "Eligible Employee" includes full-time or part-time employees of Special Districts as approved by the County Board of Supervisors.
 - c. For the purposes of this Plan, "part-time" is defined as working at least twenty (20) hours per week or forty (40) hours in a bi-weekly pay period. "Full-time" is defined as working at least forty (40) hours per week or eighty (80) hours in a bi-weekly pay period.
 - d. An "Eligible Employee" is not an employee of a temporary agency, a contractor, or any other person who does not occupy a permanent position in accordance with the annual salary ordinance.
2. Retiree
 - a. A former employee eligible for a pension from the Sacramento County Employee Retirement System (SCERS)
 - b. A former employee who has been granted a Disability Retirement and is receiving a (SCERS) pension.
3. Continuing Beneficiary: A spouse or Domestic Partner of a deceased former employee who meets the Sacramento County Employee Retirement System requirements.
4. Spouse: The Subscriber's lawful spouse as defined by California law. (The term "spouse" also includes the Subscriber's Domestic Partner as defined in "Definitions," Section 900.the State of California of the opposite sex.
5. Children: The unmarried dependent children of the Subscriber or his or her spouse or Domestic Partner (including legally adopted, natural children, step-children, children under a Medical Care Support Order, foster children and minor children for whom the Subscriber or his or her spouse or Domestic Partner is the court appointed legal guardian provided such children are dependent on the Subscriber for support.
6. Wards: Children for whom the Subscriber or his or her spouse or Domestic Partner is a court-appointed guardian.
7. Domestic Partners of Subscribers as described below and the unmarried dependent children of such Domestic Partners. The Domestic Partner and Subscriber must:
 1. Have a common residence.
 2. Agree to be jointly responsible for each other's basic living expenses incurred during the Domestic Partnership.
 3. Not be married or a member of another Domestic Partnership.
 4. Not be related by blood in a way that would prevent them from being married to each other in this state.
 5. Be at least 18 years of age.
 6. Either of the following:
 - Be members of the same sex; or
 - Be members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
 7. Be capable of consenting to the Domestic Partnership.
 8. Neither has previously filed a Declaration of Domestic Partnership with the Secretary of State that has not been terminated in accordance with the law.

9. Both file a Declaration of Domestic Partnership with the Secretary of State. **Children of the Subscriber or his or her spouse or Domestic Partner who are the subject of a Medical Child Support Order, according to state or federal law, are eligible even if they live outside the Health Net Service Area. 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.**

The Subscriber and any Family Members of the Subscriber who reside outside the Health Net Service Area may enroll based on the Subscriber's work address that is within the Health Net 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.

Age Limit for Dependent Children

Each unmarried child is eligible until the age of 19.

A Dependent child includes natural children, step-children, adopted children, children under a Medical Care Support Order, foster children and minor children for whom the Subscriber or his or her spouse or Domestic Partner is the court appointed legal guardian provided such children are dependent on the Subscriber for support. Eligibility continues until age 24 for a child who remains unmarried and who is enrolled as a full-time student and attends a certified school.

A child loses eligibility if he or she marries or ceases to be a full-time student after age 19. Any break in the school calendar will not cause the dependent child to lose eligibility for coverage.

Medical Leave of Absence from School

A covered child who has reached the age limit shown above who remains eligible due to enrollment as a full-time student according to the eligibility criteria stated above, who takes a medical leave of absence from school, will continue to be eligible for coverage under this Plan as follows:

1. If the nature of the child's injury, illness, or condition would make the child incapable of self-sustaining employment, and if the child is chiefly dependent upon the Subscriber for support and maintenance, then coverage may continue under the terms described under the "Disabled Child" heading, shown below.
2. If the nature of the child's injury, illness, or condition does not meet the eligibility conditions required to continue coverage as a disabled child, as shown below, the child's eligibility for coverage will not terminate for a period of up to 12 months, or until the date on which coverage is scheduled to terminate under the Plan, whichever comes first.

Documentation or certification of the medical necessity for a leave of absence from school must be submitted to Health Net at least 30 days prior to the medical leave of absence from school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school.

Additionally, a covered child may also reduce his or her student status from full-time to part-time (under 9 hours or equivalent units) and still be considered on a medical leave of absence from school. The covered child will continue to be eligible for coverage under this Plan under the same conditions as stated above.

Disabled Child

A child who reaches the age limit shown above is eligible to continue coverage if **all** of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

If you are *enrolling* a disabled child for new coverage, you must provide Health Net with proof of incapacity and dependency within 60 days of the date you receive a request for such information about the dependent child from Health Net. The child must have been continuously covered as a dependent of the Subscriber or his or her spouse or Domestic Partner under a previous group health plan at the time the child reached the age limit.

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

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

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

Subsection-B

How to Enroll for Coverage

Notify the Group that you want to enroll an eligible person. The Group will send the request to Health Net according to current procedures.

Employee

Eligible employees must enroll within 30 days of the date they first become eligible for this Plan. Eligible Family Members may also be enrolled at this time (see "Who Is Eligible for Coverage" above in this section).

If enrollment of the eligible employee or eligible Family Members does not occur within this time period, enrollment may be carried out as stated below in the "Late Enrollment Rule" provision of this section.

The employee may enroll on the earlier of the following dates:

- When the Plan takes effect, if the employee is eligible on that date.
- When any waiting or probationary period required by the Group has been completed.

Eligible employees who enroll in this Plan are called Subscribers.

When the employee is not subject to a probationary period, the enrollment becomes effective on the latter of:

- The first day of the month following the date of hire; or
- The first day of the month following the County's receipt of the enrollment form.

Retirees: Newly eligible retirees must enroll within 30 days of attaining Retiree status.

Continuing Beneficiary: A spouse or Domestic Partner, who qualifies as a Continuing Beneficiary as defined above, must enroll within 30 days of the death of the Retiree.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may enroll your new spouse or Domestic Partner (and your spouse's or Domestic Partner's eligible children) within 30 days of the date of marriage. Coverage begins on the first day of the month following enrollment.

Dependent Children: Dependent Children of the Employee including minor children, step-children, foster children and minor children for whom the Subscriber or his or her spouse or Domestic Partner of the Subscriber is the court appointed legal guardian must be enrolled within 30 days of the Employee's first day of employment or attainment of "Eligible status" as defined by the Employer.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child by the 30th day.

If the mother is the Subscriber's spouse or Domestic Partner and an enrolled Member, the child will be assigned to the mother's Physician Group. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another contracting Physician Group for that child, the

transfer will take effect only as stated in "Transferring to Another Contracting Physician Group" portion of this section.

Adopted Child: A newly adopted child or a child who is being adopted, becomes eligible on the date the appropriate legal authority grants the Subscriber or his or her spouse or Domestic Partner, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 30 days from the date of eligibility. The child will be assigned to the Subscriber's Physician Group. You must enroll the child before the 30th day for coverage to continue beyond the first 30 days. If you want to choose another contracting Physician Group for that child, the transfer will take effect only as stated in "Transferring to Another Contracting Physician Group" portion of this section.

Health Net will require written proof of the right to control the child's health care when you enroll him or her.

Medical Care Support Order Children: Newly eligible children of a Subscriber who are under a Medical Care Support Order must be enrolled by the subscriber within 30 days of the issuance/effective date of the Medical Care Support Order. **Legal Ward (Guardianship):** If the Subscriber or spouse or his or her Domestic Partner becomes the legal guardian of a child, the child is eligible to enroll on the Effective Date of the court order, but coverage is not automatic. The child must be enrolled within 30 days of the Effective Date of the guardianship. Coverage will begin on the first day of the month after Health Net receives the enrollment request.

Health Net will require proof that the Subscriber or spouse or Domestic Partner is the court-appointed legal guardian.

In Hospital at Time of Enrollment

If you are confined in a Hospital or Skilled Nursing Facility on the Effective Date of coverage, this Plan will cover the remainder of that confinement only if you inform the Member Services Department at the time of your enrollment about the confinement.

Health Net and your selected Physician Group will consult with your attending Physician and may transfer you to a participating facility when medically appropriate.

Late Enrollment Rule

Health Net's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" or "Newly Acquired Dependents" provisions above.)

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic enrollment forms or phone enrollments are deemed signed when you use your employer's enrollment system to make or confirm changes to your benefit enrollment.

You may have decided not to enroll upon first becoming eligible. At that time, your employer should have given you a form to review and sign. It would have contained information to let you know that there are circumstances when you will not be considered a late enrollee.

If you later change your mind and decide to enroll, Health Net can impose its late enrollment rule. This means that individuals identified on the form you signed will not be allowed to enroll before the next Open Enrollment Period. However, there are exceptions to this rule.

Exceptions to Late Enrollment Rule

If any of the circumstances below are true, the late enrollment rule will not apply to you.

1. You Did Not Receive a Form to Sign or a Signed Form Cannot Be Produced

If you chose not to enroll when you were first eligible, the late enrollment rule will not apply to you if:

- If you never received from your employer or signed, a form explaining the consequences of your decision; or
- If the signed form exists, but cannot be produced as evidence of your informed decision.

2. You Do Not Enroll Because of Other Coverage and Later the Other Coverage Is Lost

If you declined coverage in this Plan and you stated on the form that the reason you were not enrolling was because of coverage through another group health plan and coverage is or will be lost for any of the following reasons, the late enrollment rule will not apply to you.

- The subscriber of the other plan has ceased being covered by that other plan (except for either failure to pay premium contributions or a "for cause" termination such as fraud or misrepresentation of an important fact).
- Loss of coverage because of termination of employment or reduction in the number of hours of employment.
- Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area.
- Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service area, and no other benefit package is available to the individual.
- The other plan is terminated and not replaced with other group coverage.
- The other employer stops making contributions toward employee's or dependent's coverage.
- When an individual incurs a claim that would meet or exceed a lifetime limit on all benefits.
- When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual.
- The other subscriber or employee dies.
- The subscriber and his or her spouse or Domestic Partner are divorced or legally separated and this causes loss of the other group coverage.
- Loss of coverage because of cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan).
- The other coverage was federal COBRA or California Small Employer COBRA and the period of coverage ends.

3. You Lose Eligibility from a Children's Health Insurance Program (CHIP) Plan (Known in California as the Healthy Families Program), Access for Infants and Mothers Program (AIM) or a Medi-Cal Plan

CHIP is a joint federal and state program that provides comprehensive health care coverage for children under the age of 19. In California, the CHIP plan is known as the Healthy Families Program. If you become ineligible and lose coverage under the Healthy Families Program, Access for Infants and Mothers Program (AIM) or Medi-Cal, you and/or your dependent(s) will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If you and/or your dependent(s) wait longer than 60 days to enroll, you and/or your dependent(s) may not enroll until the next Open Enrollment period.

4. Multiple Health Plans

If you are enrolled as a dependent in a health plan (not Health Net) and the Subscriber, during open enrollment, chooses a different plan (such as moving from an HMO plan to a fee-for-service plan) and you do not wish to continue to be covered by it, you will not be considered a late enrollee should you decide to enroll in this Plan.

5. Court Orders

If a court orders the Subscriber to provide coverage for a spouse or Domestic Partner (a current spouse or Domestic Partner, not a former spouse or Domestic Partner) or orders the Subscriber or enrolled spouse to provide coverage for a minor child through Health Net, that spouse or child will not be treated as a late enrollee. A court ordered dependent may be added without any regard to open enrollment restrictions.

If the exceptions in 2 or 4 above apply, you must enroll within 30 days of the loss of coverage. If you wait longer than 30 days to enroll, you will be a late enrollee and you may not enroll until the next Open Enrollment Period.

Special Enrollment Rule For Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption or marriage or Domestic Partnership the following rules apply.

If the Employee Is Enrolled in this Plan

If you are covered by this Plan as a Subscriber, you can enroll your new dependent if you request enrollment within 30 days after childbirth, marriage, Domestic Partnership, adoption or placement for adoption. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

More information about enrolling new dependents and their Effective Date of coverage is available above under the heading "How to Enroll for Coverage" and the subheading "Newly Acquired Dependents."

If the Employee Declined Enrollment in this Plan

If you previously declined enrollment in this Plan because of other group coverage, and you gain a new dependent due to childbirth, marriage, Domestic Partnership, adoption or placement for adoption, you can enroll yourself and the dependent within 30 days of birth, marriage, Domestic Partnership, adoption or placement for adoption.

If you gain a new dependent due to a court order and you did not previously enroll in this Plan, you may enroll yourself and your court ordered dependent(s) without any regard to open enrollment restrictions.

In addition, any other family members who are eligible for coverage may enroll at the same time as you and the new dependent. You no longer have to wait for the next Open Enrollment Period, and whether or not you are covered by another group plan has no effect on this right.

If you do not enroll yourself, the new dependent and any other family members within 30 days of acquiring the new dependent, you will have to wait until the next Open Enrollment to do so.

The Effective Date of coverage for you and all family members who enroll within 30 days of childbirth, marriage, Domestic Partnership, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth.
- For marriage, the Effective Date will be the first of the month following enrollment.
- Regarding adoption, the Effective Date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse or Domestic Partner, in writing, the right to control the child's health care.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

Note:

When you (the employee) are not enrolled in this Plan and you wish to have coverage for a newborn or adopted child who is ill, please contact your employer as soon as possible and ask that you (the employee) and the newborn or adopted child be enrolled. An employee must be enrolled in order for his or her eligible dependent to be enrolled.

While you have 30 days within which to enroll the child, until you and your child are formally enrolled and recorded as members in our computer system, we cannot verify coverage to any inquiring medical provider.

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.

Subsection-C**Transferring to Another Contracting Physician Group**

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net," Section 100, each person 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 the Member Services Department at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

Any individual Member may change Physician Groups, that is, transfer from one to another:

- When the Group's Open Enrollment Period occurs;
- When the Member moves to a new address (notify Health Net within 30 days of the change);
- When the Member's employment work-site changes (notify Health Net within 30 days of the change);
- When determined necessary by Health Net; or
- When 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 the Member Services Department at the telephone number on your Health Net ID Card for prompt review of your request.

Effective Date of Transfer

If we receive your request for a transfer 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 we receive your request for a transfer 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 a hospitalization and you still wish to transfer after the medical condition or treatment for it has ended, please call the Member Services Department 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.)

Subsection-D**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. Coverage ends on the last day of the month in which the eligible Member(s), listed above, cease to be eligible for coverage. 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 termination due to nonpayment of subscription charges by the Group.

If the Group Service Agreement between the Group and Health Net is canceled because the Group failed to pay the required subscription charges when due, then coverage for all Subscribers and Family Members will end retroactively back to the last day of the month for which subscription charges were paid. However, this retroactive

period will not exceed the 60 days before the date Health Net mails you a Notice Confirming Termination of Coverage.

Health Net will mail your employer a Prospective Notice of Cancellation 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the subscription charges due within 15 days of the date of mailing of the Prospective Notice of Cancellation.

If Health Net does not receive payment of the delinquent subscription charges from your employer within 15 days of the date of mailing of the Prospective Notice of Cancellation, Health Net will cancel the Group Service Agreement and mail the Subscriber and your employer a Notice Confirming Termination of Coverage, which will provide you and your employer with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) the Health Net telephone number you can call to obtain additional information, including whether your employer obtained reinstatement of the Group Service Agreement (Health Net allows one reinstatement during any twelve-month period if the Group requests reinstatement and pays the amounts owed within 15 days of the date of mailing of the Notice Confirming Termination of Coverage); and (4) an explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date Health Net mails you the Notice Confirming Termination of Coverage.

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.

Subscriber and All Family Members

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.

Individual Members – Termination for Loss of Eligibility

Individual Members become ineligible on the last day of the month from the date any of the following occurs:

- The Member no longer meets the eligibility requirements established by the Group and Health Net.

This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

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

- The Member establishes primary residency outside the continental United States.
- The Member establishes primary residency outside the Health Net Service Area and does not work inside the Health Net Service Area. Subscribers terminated for such reason have the option of enrolling under the Flex Net Group Indemnity Plan entered into between the employer and Health Net Life, without the need of enrolling during the Group Annual Enrollment or without the need of submitting an Evidence of Insurability. But the Subscriber can obtain this Flex Net coverage only if no other Health Maintenance Organization (HMO) coverage is available from other carriers to the Subscriber near his or her new residence.

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 the contracting Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).

- The Member becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan.
- A Member becomes a legally emancipated minor according to state law.

- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse or Domestic Partner (now former spouse or former Domestic Partner) and that spouse's or Domestic Partner's enrolled dependents, who were related to the Subscriber only because of the marriage or Domestic Partnership, will end.

Individual Members - Termination for Cause

Health Net has the right to terminate your coverage from this plan under certain circumstances. The following are examples of circumstances that may result in a termination:

- **Disruptive or Threatening Behavior:** Your coverage may be terminated upon the date the notice of termination is mailed if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be terminated upon 15 days prior written notice if you repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net Members, or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.
- **Misrepresentation or Fraud:** Your coverage may be terminated at midnight on the date the notice of termination is mailed if you knowingly omit or misrepresent a meaningful fact on your enrollment form or fraudulently or deceptively use services or facilities of Health Net, its contracting Physician Groups or other contracting providers, (or knowingly allow another person to do so), including altering a prescription.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the Health Net conversion plan, COBRA plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future.

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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

- **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 began receiving federal COBRA coverage on or after January 1, 2003, 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* 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 by U.S. mail along with the notice 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, per-

sonal delivery, express mail, or private courier company. The address appears on the back cover of this *Evidence of Coverage*.

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:

1. 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
2. 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:

1. You have been covered for 36 months from your original COBRA Effective Date (under this or any other plan).*
2. The Member becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Member moves outside the Health Net Service Area.
4. The Member fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
5. The Group's Agreement with Health Net terminates. (See "Employer Replaces this Plan.")
6. 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.
- **Conversion Coverage:** Described below in the subsection titled "Conversion Privilege."
- **Extension of Benefits:** Described below in the subsection titled "Extension of Benefits."
- **HIPAA Guaranteed Issue Coverage:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:
 1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
 2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
 3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
 4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
 5. If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

For more information regarding guarantee issue coverage through Health Net please call the Individual Sales Department at **1-800-909-3447**. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at **1-888-HMO-2219** or visit the Department's website at www.hmohelp.ca.gov.

Subsection-E

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 "Schedule of Benefits and Copayments," Section 200, 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 "Individual Members - Termination for Cause" provision of "Eligibility, Enrollment and Termination," Section 400.

"**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. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

If benefits are extended because of total disability, provide Health Net with proof of total disability at least once every 90 days during the extension. The Member must ensure that Health Net receives this proof before the end of each 90-day period.

When the Extension Ends

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

1. On the date the Member is no longer totally disabled;
2. 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;
3. On the date that available benefits are exhausted; or
4. On the last day of the 12-month period following the date the extension began.

How Conversion Coverage Affects Extension of Benefits

• Conversion Coverage

Conversion coverage affects extension of benefits when:

1. You receive an extension of the benefits of this Plan; and
2. You have also elected conversion coverage and it is in force.

Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to the "Conversion Privilege" section immediately below.

Subsection-F

Conversion Privilege

Who Is Eligible for Conversion Coverage

Except as specified below, if you lose coverage in this Plan, you have the right to purchase individual coverage through the Health Net conversion plan without being required to complete a health statement.

You must pay the cost of conversion coverage (called subscription charges). Please note, however, that the benefits, as well as the subscription charges, will not be the same as coverage through this Group Plan.

Who Is Not Eligible for Conversion Coverage

The following people are not eligible for conversion coverage:

- Anyone who lives outside the continental United States and who does not either live or work inside the Health Net Service Area;
- Anyone whose coverage was terminated for cause as stated in "Individual Members - Termination for Cause" portion of this section;
- Anyone who is covered by another group or individual health plan; or
- Anyone who was not covered by this Plan.

How to Apply for Conversion Coverage

Request an application from Health Net. You must complete the application form and send it to Health Net within 63 days of the last day of coverage.

Anyone eligible to enroll in the Health Net conversion plan who does not enroll when Group coverage ends will not be allowed to do so at a later date.

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage. The Member must pay all required subscription charges or premiums to ensure that coverage is continuous.

Section-500

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 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.

Any covered service or supply may require a Copayment or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 200, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 600, before obtaining care.

Subsection-A

Medical Services and Supplies

Office Visits

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

Health Evaluations (including Annual Preventive Physical Examinations)

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. Coverage includes annual preventive physical examinations as directed by Your Physician, or as otherwise medically indicated.

Hearing Examinations

Ear examinations to determine the need for correction of hearing is covered as shown in the "Schedule of Benefits and Copayments," Section 200.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 200.

Immunizations and Injections

Immunizations and injections, professional services to inject the medications, and the medications that are injected are covered as shown in "Schedule of Benefits and Copayments," Section 200. This includes allergy serum.

Member Physicians will provide immunizations that are recommended by guidelines published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service or the American Academy of Pediatrics (AAP).

In addition, injectable medications (including Glucagon) 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.

Self-injectable Drugs (other than insulin), needles and syringes used with these self-injectable drugs must be obtained through Health Net's contracted Specialty Pharmacy Vendor when Prior Authorization is obtained from Health Net. Upon approval, Health Net will arrange for the distribution of drugs, needles and syringes from the appropriate Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact you directly to coordinate the delivery of your medications.

The Specialty Pharmacy Vendor will charge you for the appropriate Copayment or coinsurance shown in "Schedule of Benefits and Copayments," Section 200.

Surgical Services

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

Laboratory and Diagnostic Imaging (including X-ray) Services

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

Home Visit

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

Rehabilitation Therapy

Rehabilitation therapy services (physical, speech, and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 600.

Cardiac Rehabilitation Therapy

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

Pulmonary Rehabilitation Therapy

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

Clinical Trials

Routine patient care costs for patients diagnosed with cancer 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 "General Exclusions and Limitations" portion of "Exclusions and Limitations," Section 600, for more information.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Please refer to "Schedule of Benefits and Copayments," Section 200, for Copayment requirements.

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).

Abortions

Abortions (surgical or drug) are covered by this Plan whether they are elective or Medically Necessary.

Copayment requirements may differ between the two. Refer to "Schedule of Benefits and Copayments," Section 200.

The contracting Physician Group and Health Net will determine whether an abortion is Medically Necessary or elective.

Family Planning

Counseling, planning and other services for problems of fertility are covered.

Included in these other services are:

- Fitting examination for a vaginal contraceptive device (diaphragm and cervical cap).
- Inserting an intrauterine device (IUD).
- Sterilization

Infertility services (including artificial insemination procedures, office visits, follicle ultrasounds and sperm washing) and supplies are also covered, but there are significant exclusions. Please refer to the "Conception by Medical Procedures" portion of "Exclusions and Limitations," Section 600, for more information.

Please refer to "Schedule of Benefits and Copayments," Section 200, under the heading "Family Planning" for information regarding contraceptives covered under the medical benefit.

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.

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.

Home Health Care Services

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

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

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

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See "Definitions," Section 900. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

Custodial Care services and Private Duty Nursing, as described in "Definitions," Section 900 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) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See "Definitions," Section 900.

Ambulance Services

Air and ground ambulance services are covered.

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible and they must authorize the services. All paramedic, ambulance, and ambulance transport services provided as a result of a **911** emergency response system call will be covered, when the criteria for Emergency Care, as defined in this *Evidence of Coverage*, have been met.

Hospice Care

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.

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, nebulizers (including face masks and tubing) and Hospital beds, is covered and will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health Net applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), HCPCS Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage. Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing) and orthotics are not subject to such quantity limits.

Diabetic Equipment/Supplies

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective footwear to prevent or treat diabetes-related complications
- Blood glucose monitors designed to assist the visually impaired
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunization and Injections" portion of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" portion of this section for more information.

These following items are covered under your Medicare Part D Prescription Drug benefits issued to you in a separate Evidence of Coverage:

- Insulin and Prescription Drugs for the treatment and management of diabetes
- Specific brands of blood glucose monitors and blood glucose testing strips
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Specific brands of pen delivery systems for the administration of insulin, including pen needles
- Specific brands of disposable insulin needles and syringes

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. If you live 50 miles or more from the nearest Health Net Bariatric Surgery Performance Center, you are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by Health Net. Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of three (3) trips (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 two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Member and one companion not to exceed \$100 per day for the 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 not to exceed \$100 per day for the duration of the Member's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

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

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donation, including how to elect to be an organ donor, please contact the Member Services Department 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.

Renal Dialysis

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

Prostheses

Internal and external prostheses required to replace a body part are covered. 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 internally implanted devices such as heart pacemakers.

In addition, prostheses to restore symmetry after a Medically Necessary mastectomy are covered.

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

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

Prostheses are covered as shown under "Medical Supplies" in "Schedule of Benefits and Copayments," Section 200.

Blood

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

Inpatient Hospital Confinement

Care in a room of two or more beds or in a licensed special treatment unit 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 determined to be Medically Necessary.

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 "Schedule of Benefits and Copayments," Section 200 for more information.

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 "Exclusions and Limitations," Section 600. However, effective July 1, 2010, reconstructive surgery does include Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

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

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 "Schedule of Benefits and Copayments," Section 200.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

To request an authorization for a second opinion, contact your Primary Care Physician or the Member Services Department at the telephone number on your Health Net ID card. Physicians at your Physician Group or Health Net will review your request in accordance with Health Net's procedures and timelines as stated in the second opinion policy. You may obtain a copy of this policy from the Member Services Department.

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

Surgically Implanted Drugs

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

Subsection-B**Chiropractic Services and Supplies**

Please read the "Chiropractic Services and Supplies" portion of "Exclusions and Limitations," Section 600.

Chiropractic Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 200.

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. 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.

All covered Chiropractic Services require pre-approval by ASH Plans except:

- A new patient examination by a Contracted Chiropractor and the provision or commencement, in the new patient examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic Services including, without limitation, any referral for x-ray services, radiological consultations, or laboratory services.

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, as set forth in a treatment plan approved by ASH Plans, 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 and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans 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 and approved by ASH Plans for up to the maximum benefit shown in "Schedule of Benefits and Copayments," Section 200.

Subsection-C

Eyewear

Eye examinations to determine the need for correction of vision are not covered. Vision Care is covered through a direct contract between County of Sacramento and Vision Service Plan. Please refer to your Vision Service Plan Summary Plan Description for benefits or contact them Vision Service Plan at **1-800-877-7195**.

Subsection-D**Mental Disorders and Chemical Dependency**

The Mental Health 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.

To be covered, the Behavioral Health Administrator must authorize these services and supplies. In an emergency, call **911** or contact the Behavioral Health Administrator at the Member Services Department telephone number shown on your Health Net ID Card before receiving care. For additional information on accessing mental health services, visit our website at www.healthnet.com and select the MHN link. The Behavioral Health Administrator will refer you to a nearby Participating Mental Health Professional or participating independent Physician or provider association (IPA) sub-contracted by the Behavioral Health Administrator. That professional or association will evaluate you to determine if additional treatment is necessary. If you need treatment, the Participating Mental Health Professional or IPA will develop a treatment plan and submit that plan to the Behavioral Health Administrator for review. When authorized by the Behavioral Health Administrator or sub-contracted entity thereof, the proposed services will be covered by this Plan.

If the Behavioral Health Administrator does not approve the treatment plan, no further services or supplies will be covered for that condition. However, the Behavioral Health Administrator may direct you to community resources where alternative forms of assistance are available.

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 request a copy of our continuity of care policy, please call the Member Services Department at the telephone number on your Health Net ID Card.

The following benefits are provided:**Outpatient Services**

Outpatient services are covered as shown in "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits."

Covered services include:

- Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Chemical Dependency.
- Medication management care, when appropriate.

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.

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 "Schedule of Benefits and Copayments," Section 200, 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 "Exclusions and Limitations," Section 600.

Intensive Outpatient Program

Intensive outpatient care program is covered as shown in "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits." 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 Program

Partial hospitalization/day treatment program is covered as shown in "Schedule of Benefits and Copayments," Section 200, under "Mental Disorders and Chemical Dependency Benefits." 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.

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 "Schedule of Benefits and Copayments," Section 200.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 200.

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 the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Section-600

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.

Subsection-A

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*.

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the *Evidence of Coverage*, exceed *Evidence of Coverage* 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).

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, 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 primarily to assist with the activities of daily living, regardless of where performed.

Custodial Care 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 or physical therapist.

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 "General Provisions," Section 700, for more information; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500.

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

Home Birth

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

Ineligible Status

This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered, except as specified in "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

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

No-Charge Items

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

Personal or Comfort Items

This Plan does not cover personal or comfort items.

Unlisted Services

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

Subsection-B**Services and Supplies**

In addition to the exclusions and limitations shown in the "General Exclusions and Limitations" portion of this section, the following exclusions and limitations apply to 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.

Blood

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

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See "General Provisions," Section 700, 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 is covered when a female Member or her male partner is infertile (refer to Infertility in "Definitions," Section 900). However, if only the male partner is a Member and the female partner (who is not a Member) is infertile, artificial insemination will not be covered. 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), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.

Contraceptives

Contraceptives are limited to injectable contraceptives. Fitting examinations and the insertion of vaginal contraceptive devices are covered as shown under the "Family Planning" portion of "Covered Services and Supplies" Section 500.

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 transplantation, hair analysis, hair-pieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin, liposuction or epilation are not covered.

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

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

Then, the following are covered:

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to remove or reduce skin or tissue; or
- Effective July 1, 2010, reconstructive surgery does include 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 has been performed, the following are covered:

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

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

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

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 "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 100, 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, are

subject to the other exclusions and limitations of this Evidence of Coverage and will only be covered under the following circumstances (a) Members who are under 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.
- Effective July 1, 2010, this plan also covers 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.

- 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
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 500).

Disorders of the Jaw

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

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

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)
- Stockings, corrective shoes and arch supports
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools

- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Orthotics, unless custom made to fit the Member's body. (Orthotics are supports, or braces for weak or ineffective joints or muscles.) Foot orthotics are subject to the benefit limitations as stated in the following provision for "corrective footwear".
- Corrective footwear (whether or not custom fit), that are not incorporated into cast, splint, brace or strapping of the foot, except when Medically Necessary for the management and treatment of diabetes.

The Plan covers Medically Necessary diabetic supplies as shown in "Medical Supplies" portion of "Schedule of Benefits and Copayments," Section 200 and "Diabetic Equipment" portion of "Covered Services and Supplies," Section 500. Visual aids (excluding eyewear) to assist the visually impaired in the proper dosing of insulin are covered as described in the "Prostheses" portion of the "Covered Services and Supplies" Section 500.

Educational and Employment Services

Services related to educational and professional purposes are not covered, including ancillary services such as:

- Vocational rehabilitation.
- Employment counseling, training or educational therapy for learning disabilities.
- Investigations required for employment.
- Education for obtaining or maintaining employment, or for professional certification.
- Education for personal or professional growth, development or training.
- Academic education during residential treatment.

Electro-Convulsive therapy

Electro-Convulsive therapy is not covered except as authorized by the Behavioral Health Administrator.

Eyewear

Eye examinations to determine the need for correction of vision are not covered. Vision Care is covered through a direct contract between County of Sacramento and Vision Service Plan. Please refer to your Vision Service Plan Summary Plan Description for benefits or contact Vision Service Plan at **1-800-877-7195**.

Genetic Testing and Diagnostic Procedures

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

Hearing Aids

This Plan does not cover any analog or digital hearing aid devices, which typically fit in or behind the outer ear and are used to improve hearing.

Nonabstinence-Based Treatment

Chemical Dependency treatment not based on abstinence is not covered.

Noncovered Treatments

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

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

Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment.

In addition treatment by providers who are not within licensing categories that are recognized by the Behavioral Health Administrator as providing Covered Services in accordance with applicable medical community standards is not covered.

Non-eligible Institutions

This Plan only covers services or supplies provided by a legally operated Hospital, 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.

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

Medical equipment and supplies that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a prescription drug order is not covered even if a Physician writes a prescription drug order for such drug, equipment or supply.

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, biofeedback (except for certain physical disorders, such as incontinence and chronic pain), hypnotherapy and crystal healing therapy are not covered.

Nontreatable Disorders

Mental Disorders or conditions of Chemical Dependency that the Behavioral Health Administrator determines are not likely to improve with generally accepted methods of treatment are not covered.

Outpatient Prescription Drugs

Outpatient Prescription Drug benefits are not covered under this medical Plan. Please refer to Medicare Part D Prescription Drug benefits issued to you in a separate Evidence of Coverage.

However, diabetic equipment and supplies for the management and treatment of diabetes are as shown in the “Diabetic Equipment” portion of “Covered Services and Supplies,” Section 500.Physician Self-Treatment

This Plan does not cover Physician self-treatment rendered in a non-emergency. 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.

Psychological Testing

Psychological testing is only covered when ordered by a licensed Participating Mental Health Professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Disorder or condition of Chemical Dependency.

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 licensed physical, speech or occupational therapist for treatment of conditions resulting from a Defined Disease, injury or surgical procedure. The services must be at a level of complexity that requires the judgment, knowledge and skills of a licensed physical, speech or occupational therapist, be based on a treatment plan and be provided by such therapist or under the therapist's direct supervision. Such services are not covered when medical documentation

does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See "General Provisions," Section 700, for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Residential Treatment Center

Admissions that are not considered medically appropriate 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.

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 "Health Evaluations (including Annual Preventive Physical Examinations)" in "Covered Services and Supplies," Section 500, for information about coverage of examinations that are for preventive health purposes.

Services Not Related To Covered Condition, Illness Or Injury

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

Sex Change

This Plan does not cover procedures or treatment related to changing a Member's physical characteristics to those of the opposite sex.

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an Emergency or Urgently Needed Care as defined in "Definitions," Section 900.

Surrogate Pregnancy

This Plan covers services for a surrogate pregnancy 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.

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 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 the Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders or Chemical Dependency) according to Health Net's or 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.

Subsection-C

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 500, for more information.

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

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

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 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.

Section-700**GENERAL PROVISIONS****Subsection-A****When the Plan Ends**

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

If you are hospitalized or totally disabled on the date that the Group Service Agreement is terminated, benefits will continue according to "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

Subsection-B**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 "Eligibility, Enrollment and Termination" Section 400, Subsection D, "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.

Subsection-C**Member Services Department Interpreter Services**

Health Net's Member Services Department has bilingual staff and interpreter services 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 Member Services staff can help you find a health care provider who speaks your language. Call the Member Services 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;
- 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 with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Subsection-D**Grievance, Appeals, Independent Medical Review and Arbitration****Grievance Procedures**

Appeal, complaint or grievance means any dissatisfaction expressed by You or Your representative concerning a problem with Health Net, a medical provider or Your coverage under this EOC. If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Member Services Department at **1-800-522-0088** or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com. You may also file your complaint in writing by sending information to:

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

If your concern involves the Mental Disorders and Chemical Dependency program call MHN Services at **1-888-426-0030**, or write to:

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

If your concern involves the chiropractic program, call American Specialty Health Plans of California, Inc. (ASH Plans) at **1-800-678-9133** or write to:

American Specialty Health Plans of California, Inc.
Attention: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

You must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. Please include all information from your Health Net Identification Card and the details of the concern or problem.

We will:

- Confirm in writing within five calendar days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

Eligibility

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

- 1.(A) Your provider has recommended a health care service as Medically Necessary or

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

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

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

For more information regarding the IMR process or to request an application form, please call the Member Services Department at **1-800-522-0088**.

Independent Medical Review of Investigational or Experimental Therapies

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

Eligibility

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

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide

information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Member Services Department at **1-800-522-0088**.

Subsection-E

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan.)

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-400-8987** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, then you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that 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.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the

total amount of damages claimed is \$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 provides for judicial review of arbitration proceedings.

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

Subsection-F

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, 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.

Subsection-G

Medical Malpractice Disputes

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

Subsection-H

When A Third Party Causes A Member Injuries

If you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money because of your injuries, you must reimburse Health Net or the medical providers for the value of any services provided to you through this Plan.

Examples of how an injury could be caused by the actions of another person:

- You are in a car accident and the other driver is at fault; or
- You slip and fall in a store because a wet spot was left on the floor

Steps You Must Take

Health Net's legal right to reimbursement is called a lien.

If you are injured because of a third 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 third party, if you know it, the name and address of your lawyer, if you are using a lawyer, 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 third parties or their insurance companies and
- Holding any money that you or your lawyer receive from the parties, or their insurance companies in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

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 and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.

- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro rated 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.

Subsection-I

Relationship of Parties

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

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

All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of this Plan.

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

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

In addition, a Member may request continued care from a 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 "Definitions," Section 900 of this *Evidence of Coverage*.

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 Member Services Department 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.

Subsection-J

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.

- A. **"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.
- (1) **"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 "Government Coverage" portion of this "General Provisions," Section 700.)
 - (2) **"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.

- B. **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.

- C. **Allowable Expense**—This concept means a health care service or expense, including Deductibles and 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 Expense**:

- (1) 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.

- (2) 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.
- (3) 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.
- (4) 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.
- (5) 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.

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

- F. **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.

- A. **Primary or Secondary Plan**—The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- B. **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.
- C. **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.
- D. **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.
1. **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.
 2. **Child Covered By More Than One Plan**—The order of payment when a child is covered by more than one Plan is:
 - a. **Birthday Rule**—The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - 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.
 - b. **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.
 - c. **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.
 3. **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.

4. **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.
5. **Longer or Shorter Length of Coverage**—If the preceding rules do not determine the order of payment, the Plan that covers the Subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
 - a. **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.
 - b. **New Plan Does Not Include**—The start of a new Plan does not include:
 - (i) A change in the amount or scope of a Plan's benefits.
 - (ii) A change in the entity that pays, provides or administers the Plan's benefits.
 - (iii) A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).
 - c. **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.
6. **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

- A. **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.
- B. **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.

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

Subsection-K

Government Coverage**Medicare Coordination of Benefits (COB)**

When you or your spouse reaches 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. Notwithstanding any other provision in this Evidence of Coverage, we will 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 Parts A and Part B, and are not an active employee or your employer group has less than twenty employees, then this Plan will be the secondary plan. Please note that you must enroll in Medicare Part A and Part B to be eligible for Medicare Coordination of Benefits.

For services and supplies covered under Medicare Part A and Part B, claims are first submitted 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 Covered Services outlined in this *Evidence of Coverage*, subject to any limits established by 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*.

For answers to questions regarding Medicare, contact:

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

Write to:

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

Medi-Cal

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

Veterans' Administration

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

Subsection-L

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, your Physician Group 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.

Section-800

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. Your Physician Group performs or authorizes all care and you will not have to file claims.

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

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

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

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 one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Member Services Department 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 for other covered Chiropractic 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: Member Services Department
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, 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 it was filed as soon as reasonably

possible. You must use the CMS (HCFA) - 1500 form in filing the claim, and you should send the claim to MHN 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 "Emergency and Urgently Needed Care" section under "Introduction to Health Net," Section 100.

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. 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*.

Confidentiality of Medical Records

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

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net (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. We must follow the terms of this Notice

while it is in effect. 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.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

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.

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.

Other Uses Or Disclosures With An Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. 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 records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **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 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 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.

- **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 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. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new Effective Date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us 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: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: **1-800-400-8987**
Fax: **1-818-676-8314**
Email: Privacy@healthnet.com

* *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.*

Section-900

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.

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 Services through a network of Contracted Chiropractors.

Behavioral Health Administrator is an affiliate behavioral health services administrator which contracts with Health Net 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.

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 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 a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 200.

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.

Defined Disease is any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis are known.

Domestic Partner is a person eligible for coverage provided that the partnership with the Subscriber meets all Domestic Partnership requirements under California law or other recognized state or local agency. The Domestic Partner and Subscriber must:

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the Domestic Partnership.
6. Be either of the following:
 - Members of the same sex; or
 - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
7. Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

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).
- Withstands repeated use.
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would seek if he or she was having serious symptoms and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger)
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery or
- A transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility or by transferring the Member to another facility as Medically Necessary to treat the Psychiatric Emergency Medical Condition.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Emergency 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 reasonable layperson, with no special knowledge of health or medicine or chiropractic, could reasonably expect that a delay of immediate attention 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.

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, "Experimental" services are chiropractic care that is an unproven Chiropractic Service that does not meet professionally recognized, valid, evidence-based standards of practice.

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

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

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 Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members, and provide benefits through approved health plans.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in 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 is not covered under this Plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

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

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility exists when any of the following apply to a female Member who has not yet gone through menopause:

- The Member has had regular heterosexual relations on a recurring basis for one year or more without use of contraception or other birth control methods and has not become pregnant, or if she became pregnant, could not achieve a live birth; 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.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

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

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

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

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

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

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

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

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

Member is the Subscriber or an enrolled Family Member.

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

Mental Disorders are nervous or mental conditions that meet all of the following criteria:

- 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.

Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

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 period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change Physician Groups at this time.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted or on any date approved by Health Net.

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. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in "Out-of-Pocket Maximum," Section 300.

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.

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

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Chemical Dependency rehabilitation services.

Participating 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 and Chemical Dependency rehabilitation services.

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by the Group and described in the Group Service Agreement and this *Evidence of Coverage*.

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.

Private Duty Nursing means continuous or complex nursing services provided by a licensed nurse (RN or LPN) for a patient who requires more individual and continuous care than is normally available during a skilled nursing care visit or is normally and routinely provided by the nursing staff of a hospital or skilled nursing facility. Continuous nursing services mean nursing services (including intermittent services separated in time, such as 4 hours in the morning and 4 hours in the evening) that exceeds a total of eight hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or other non-institutional setting such as home or school. Private Duty Nursing may also be referred to as "shift care."

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.

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 is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, 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:

- 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; 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*), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

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 Pharmacy Vendor is a pharmacy contracted with Health Net specifically to provide injectable medications, needles and syringes.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this *Evidence of Coverage*. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of his or her family who meet the eligibility requirements of the Group and Health Net.

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 is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine 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 reasonably have known an emergency did not exist.

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 điện 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

Contact us

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

Large Group:

1-800-400-8987
(for companies with 51 or
more employees)

Optimizer HMO HRA

Dedicated Customer Contact Center:

1-800-431-9059

Small Business Group:

1-800-361-3366
(for companies with 2-50 employees)

Individual & Family Plans:

1-800-839-2172

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

1-800-995-0852

www.healthnet.com