Health Net
Medicare Programs

A COMPLETE

explanation of your plan

Health Net Medical Plan

For University of California Medicare members
in Madera, Nevada or Ventura Counties
Effective 1/1/2011

Evidence of Coverage
Health Net Medicare
Coordination of Benefits (MED/COB)
Plan 3KS
EOCID: 304578

Schedule changes in 2011

This page is not an official statement of benefits. Your benefits are described in detail in the *Evidence of Coverage*. We have also edited and clarified language throughout the *Evidence of Coverage* in addition to the items listed below.

Changes to this Plan

- Out of Pocket Maximum – Covered Medical Services apply to the $1500 per member annual copayment maximum.
- Urgent Care service copayment - The Urgent Care copayment has been changed from $50 to $15.
- Medical Inpatient, Substance Abuse Inpatient, Mental Health Inpatient, and Detoxification Inpatient - Under the **"Schedule of Benefits"** The $250 limit to first three inpatient admission per calendar year has been removed.
- Glaucoma tests The copayment for Glaucoma testing has been changed from $15 to $0

Note:
Once you enroll in Medicare, your behavioral health provider network will be different and you will need to obtain new authorizations/self referrals to behavioral health providers. Please review your Health Net ID card for the appropriate phone number for Mental Health and Substance Abuse.

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/uc. You can also elect to have a hard copy of this Evidence of Coverage mailed to you by calling the Member Services Department at 1-800-539-4072.

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 9.

The following words are used frequently:

"You" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.

"Employee" has the same meaning as the word "you" above.

"We" or "Our" refers to Health Net.

"Subscriber" means the primary covered person, generally an Employee of a Group.

"Physician Group" or "Participating Physician Group (PPG)" means the medical group 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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1. University of California - Eligibility, Enrollment, Termination and Plan Administration Provisions

January 1, 2011

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

The covered services and supplies of this Plan are available to the following people as long as they live in the continental United States, either work or live in the Health Net Service Area, and meet any additional eligibility requirements of the Group and this Evidence of Coverage:

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

****** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan provided that you must also meet the following requirements:
(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and
(c) you elect to continue (or effective 1/1/05 suspend) medical coverage at the time of retirement.

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members, including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), domestic partner verification, adoption records, Federal Income Tax Return, or other official documentation.

Eligible Adult:

Spouse: Your legal spouse.

Same Sex-Domestic Partner: You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations.

Opposite-Sex Domestic Partner: The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

Note: An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 and continues to be ineligible for Medicare Part A may continue coverage in UC-sponsored plans.

Child: All eligible children must be under the limiting age of 26 (18 for legal wards except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition). The following categories are eligible:
(a) your natural or legally adopted children;
(b) your spouse's natural or legally adopted children (your stepchildren);
(c) your eligible domestic partner's natural or legally adopted children;

(d) grandchildren of you, your spouse or your eligible domestic partner if living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
(e) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
(f) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner's for support and maintenance; and
- the child is claimed as your , your spouse, or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage or adoption), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). UC dependent eligibility requirements may change following final health care reform legislation, regulatory guidance, or other applicable laws.

Other

No Dual Coverage
Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may enroll and cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information
For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the UC Customer Service Center by the last business day within the applicable enrollment period, Electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)
A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. If the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day when enrolling with forms.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

(c) For a natural child, on the child's date of birth.

(d) For an adopted child, the earlier of:
(i) the date the child is placed for adoption with the Employee/Retiree, or
(ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(e) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the service area.

At Other Times for Employees and Retirees

Group Open Enrollment Period. You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

90-Day Waiting Period. If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the "Special Circumstances" described below applies.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

Newly Eligible Child. If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:

   a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

   b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.

   c. Your coverage under the other health plan wherein you or your eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or CalCOBRA continuation was exhausted, or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.

   d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day. Electronic transactions must be completed by the deadline on the last day of the enrollment period.

3. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)

~~4.~~ You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin). Retirement alone does not grant a PIE to enroll or change your medical plan.

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or
(b) a maximum of 60 days prior to the date your Child's enrollment form is received by your local Benefits or Payroll Office..

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California *Medicare Declaration* form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's *Medicare Declaration* form is available through the UC Customer Service Center or from the website: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be deenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this

Plan, benefits will cease to be provided and you may have to pay for the cost of those services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status, or retirement.

Optional Continuation of Coverage

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act,, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the group insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and plan administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by Health Net. If you have a question about benefits under the Plan or about a specific claim, please contact Health Net at the following address and phone number:

Health Net Medicare COB
P.O. Box 10198
Van Nuys, CA 91410-09108
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047RC, G, M, R, V, Z, 5047SD, J, N, S, W, 5047TB, H, M, S, X, 5047UC, G, M, T, Y, 5047VC, H

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The portion of the

premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements
The benefits under the Plan are provided by (carrier's name) under a Group Service Agreement.

The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on (carrier's name) at the address listed above.

Your Rights under the Plan
As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan
To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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.

Effect of Medicare

If you are eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. Once you and/or a family member are enrolled in Medicare, you are ineligible for mental health and substance abuse benefits through the United Behavioral Health portion of your plan. Employees should contact the local benefits office and Retirees should contact the University's Customer Service Center to transfer to the portion of your plan for Medicare enrollees.

2. Introduction to Health Net
Medicare Coordination of Benefits (COB)

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 1-800-539-4072 to ensure that you can obtain the health care services that you need.

Transition of Care For New Enrollees

You may request continued care from a provider, including a Hospital, that does not contract with Health Net if, 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 9.

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 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.

Selecting a Contracting Physician Group

Each person must select a Primary Care Physician at a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. Family Members may select different contracting Physician Groups.

Subscriber who resides outside the Health Net Service Area, 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 I.D. 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/uc.

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net," Section 2, 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 pregnancy, illness, injury, hospitalization, or surgery, 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 pregnancy ends.
- 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.

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 "General Provisions," Section 7.

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 3.

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.

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 "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 Substance Abuse) 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 9, 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 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 personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital, as Medically Necessary. .
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 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.

3. Schedule of Benefits and Copayments

Health Net's Medicare Coordination of Benefits (COB) plan is offered to Medicare eligible retirees. To be eligible, retirees must reside within the Health Net HMO service area (see Eligibility, Enrollment and Termination). The Medicare COB plan works just like a traditional HMO plan, but coordinates the cost of care with Medicare as the primary payor. On the Medicare COB plan, you do not assign your Medicare Part A & B to Health Net, preserving the portability of your basic Medicare benefits. With the exception of emergency care, Medicare deductibles and coinsurance are not covered by Health Net when utilizing out-of-network services, or services not coordinated through your Primary Care Physician."

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 4, for more information.

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

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

Copayment Exceptions

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

Office Visits

	Copayment
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)	$15
Periodic health evaluation, (including well-baby care for a child who is eligible under this Medicare COB plan) and (includes annual preventive physical examinations)	$0
Annual routine physical examination	$0
Vision or 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 5.)

Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$15
Allergy injection services	$15
Allergy serum	$0
Immunizations for occupational purposes or foreign travel	20%
Other immunizations	$0
Office based injectable medications (per dose)	$15
All other injections	$0

Rehabilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Pulmonary rehabilitation therapy	$15
Cardiac rehabilitation therapy	$15

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 6.

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$0
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 in Contracting Physician Group's office	$15
Elective abortions in Hospital	$0
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
Sterilization of females in Contracting Physician Group's office	$15
Sterilization of females in Hospital	$0
Sterilization of males in Contracting Physician Group's office	$15
Sterilization of males in Hospital	$0
Contraceptive devices	Not covered
Injectable contraceptives (including but not limited to Depo Provera)	$0
Removal of implantable contraceptive devices (including but not limited to Norplant)	
Medically necessary removal	$60
Voluntary removal (requested by Member)	$60

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.

Other Professional Services

	Copayment
Surgery in Hospital	$0
Assistance at surgery	$0
Transgender 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
Podiatry services (determined Medically Necessary by the contracting Physician Group)	$15

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.

Transgender surgery requires prior authorization from Health Net. Transgender surgery and services related to the surgery, that are authorized by Health Net are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. Reasonable travel, lodging and meal costs, as determined by Health Net, for a Member to undergo an authorized transgender surgery are included within the lifetime benefit maximum.

Routine podiatry services (cutting/removal of corns or calluses, trimming of nails, preventive maintenance care) are limited to 1 visit each calendar month. Medically necessary podiatry services covered by Medicare are covered with no limit.

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
Corrective Footwear (for the treatment of conditions not related to diabetes)**	$0
Prostheses (internal or external)	$0
Blood or blood products	$0
Hearing Aids (2 standard Hearing Aids (analog or digital) every 36 months up to $2,000 total benefit maximum)	$0

Notes

Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and corrective footwear. Please see "Diabetic Equipment" in "Covered Services and Supplies," Section 5.

A standard Hearing Aid (analog or digital) is one that restores adequate hearing to the Member and is determined to be Medically Necessary and authorized by the Members Physician Group.
No benefits will be provided for hearing aid charges which exceeds specifications prescribed for the correction of hearing loss.
*For a complete list of covered diabetic equipment and supplies, please see "Diabetic Equipment" in "Covered Services and Supplies," Section 5
**Corrective footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary.

Home Health Care Services

	Copayment
Home health visits	$0
Home IV therapy	$0

Hospice Services

	Copayment
Hospice care (when you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare).	$0

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or special care unit including ancillary (additional) services	$250

Note

Inpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Outpatient Hospital Services

	Copayment
Outpatient facility services (other than surgery)	$0
Outpatient surgery (Hospital or Outpatient Surgical Center charges 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.

Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the periodic health evaluation benefit as stated in the "Office Visits" section above. If, during the course of a screening colonoscopy or sigmoidoscopy procedure, a therapeutic (surgical) procedure is performed, then the Copayment or coinsurance applicable for outpatient surgery will be required for the surgical procedure(s) performed. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or coinsurance applicable for outpatient facility services.

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

Outpatient Hospital Services for transgender surgery and services related to the surgery require Prior Authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Skilled Nursing Facility Services

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

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	$15
Each subsequent visit	$15
Re-examination visit	$15
Second opinion	$15

Note

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

Limitations

Up to 20 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

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 Schedule

	Eyewear Allowance
Standard Progressive Lenses (add-on to bifocals)	Health Net Vision pays the first $100 then the Member pays 80 % of the remaining balance, if applicable.

Standard Plastic Eyeglass Lenses (one pair every 24 months):

Single vision	Health Net Vision pays in full
Bifocal	Health Net Vision pays in full
Trifocal	Health Net Vision pays in full
Lenticular	Health Net Vision pays in full
Standard Progressive Lenses (add-on to bifocals)	Health Net Vision pays in full after $65 Copayment
Premium Progressive Lenses (add-on to bifocal)	You pay $65 Copayment, plus plus 80% of charge, less $120 allowance

Eyeglass Lens Options (for one pair every 24 months):

UV Coating	20% discount
Tint (Solid and Gradient)	20% discount
Standard Plastic Scratch-Resistance	20% discount
Standard Polycarbonate	20% discount

Standard Anti-Reflective ..... 20% discount
Other Add-Ons and Service ..... 20% discount

Contact Lenses (in lieu of Eyeglass Lenses; includes material only):

Conventional Contact Lenses (one pair every 24 months) ..... Health Net Vision pays the first $100, then the Member pays 85% of the remaining balance, if applicable.

Disposable Contact Lenses ..... Health Net Vision pays the first $100, Member pays the remaining balance.
(If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact Lenses to reach the allowable amount shown in "Eyewear Schedule" at one visit. If you do not use the full $100 allowed amount during the initial purchase, the remaining balance will not carry over)

Medically Necessary Contact Lenses* (one pair every 24 months) ..... Health Net Vision pays in full

*Contact Lenses are defined as Medically Necessary if the individual is diagnosed with one of the following conditions:

- Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

Mental Disorders and Benefits

Copayments for covered services provided for the treatment of Mental Disorders and Substance Abuse 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	$250 per admission
Intensive outpatient care or partial hospitalization/day treatment	$0

Other Mental Disorders	***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	$250 per admission
Intensive outpatient care or partial hospitalization/day treatment	$0
Telephonic clinical consultations (limited to a maximum of 3 consultations per member per calendar year)	Covered in full

Substance Abuse	***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	$250 per admission
Intensive outpatient care or partial hospitalization/day treatment	$0
Detoxification	$250 per admission

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.

Note

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

For Telephonic clinical consultations please call Managed Health Network (MHN) at 1-800-663-9355.

Prescription Drugs

Prescription Drugs are covered as described in the separate Medicare Prescription Drug Plan Evidence of Coverage included with this mailing. You can also obtain a copy at www.healthnet.com/uc.

4. Out-of-Pocket Maximum

The Out-of-Pocket Maximum (OOPM) amount below are the maximum amounts you must pay for covered services during a particular Calendar Year.

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

The OOPM amounts for this Plan (Excludes Prescription Drugs) is:

One Member .....$1,500.

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.

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.

5. 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 3, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 6, before obtaining care.

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.

Periodic Health Evaluations **(including annual preventive physical examinations)**

The coverage described below shall be consistent with the requirements of the Patient Protection and Affordable Care Act (PPACA)

For preventive health purposes, covered services include, but are not limited to, periodic health evaluations and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and 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.

Vision and Hearing Examinations

Eye and ear examinations to determine the need for correction of vision and hearing are covered. Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

Hearing Aids

Standard hearing devices (analog or digital), which typically fit in or behind the outer ear, used to restore adequate hearing to the Member and determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to "Schedule of Benefits and Copayments," Section 3 for more information.

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 3.

*The coverage described above meets the requirements of the **Patient Protection and Affordable Care Act (PPACA),** which states:*

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Member Services Department at the phone number on your Health Net I.D. card.

Immunizations and Injections

The coverage described below shall be consistent with the requirements of the Patient Protection and Affordable Care Act (PPACA).

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 3. 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), and 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 the separate Medicare Prescription Drug Plan Evidence of Coverage.

Surgical Services

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

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.

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 6.

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 The General Exclusions and Limitations," portion of "exclusion and Limitations", Section 6, for more information.

Pregnancy

The coverage described below meets requirements for Hospital length of stay under the Newborns' and Mothers' Health Protection Act of 1996.

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 3, 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.

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 elective and Medically Necessary abortion. Refer to "Schedule of Benefits and Copayments," Section 3.

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).

Please refer to "Schedule of Benefits and Copayments," Section 3, under the heading "Family Planning" for information regarding contraceptives covered under the medical benefit.

Additional contraceptive, supplies, and devices may be covered, except as stated in the "Prescription Drugs" portion of this section under the heading "Contraceptives" for more information

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 home bound 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 9. 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 9 and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See “Definitions,” Section 9.

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" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a Hospice facility, a Hospital, or a nursing home. Care from a Hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

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, bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered . Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts). Corrective Footwear (including shoes, inserts or foot Orthotics) is covered as Medically Necessary when it is custom made for the Member. Corrective Footwear for the management and treatment of diabetes is covered under the “Diabetic Equipment” benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Health Net 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.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Durable Medical Equipment" portion of "Exclusions and Limitations," Section 6. Please refer to "Schedule of Benefits and Copayments," Section 200 for the applicable Copayment or coinsurance.

Diabetic Equipment

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.

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

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

Evaluation of potential candidates is subject to prior authorization. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is 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 2.

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 and radiation therapy) are subject to the same Copayment which is required when these services are performed at your physician group.

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 3, of this *Evidence of Coverage* for more information.

Outpatient Hospital Services for transgender surgery and services related to the surgery require Prior Authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

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

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies 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.

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

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 3.

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.

Transgender Surgery and Services

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Mental Disorders and Substance Abuse

Please read the "Mental Disorders and Substance Abuse" portion of "Exclusions and Limitations," Section 6.

The Mental Health and Substance Abuse benefits are administered by a specialized health care service Plan which contracts with Health Net to underwrite and 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 telephone number shown on your Health Net ID Card before receiving care.

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 3, under "Mental Disorders and Substance Abuse Benefits."
Covered services include:

- Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Substance Abuse.
- 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 Substance Abuse is covered as shown in "Schedule of Benefits and Copayments," Section 3, under " Mental Disorders and Substance Abuse 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 6.

Intensive Outpatient Program

Intensive outpatient care program is covered as shown in "Schedule of Benefits and Copayments," Section 3, under "Mental Disorders and Substance Abuse 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 3, under "Mental Disorders and Substance Abuse 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 Substance Abuse 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 3.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 3.

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

Chiropractic Services and Supplies

Please read the "Chiropractic Services and Supplies" portion of "Exclusions and Limitations," Section 6.

Chiropractic Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 3.

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.
- A re-examination may be performed by the Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-examination may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

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 3.

Eyewear

Please read the "Eyewear" portion of "Exclusions and Limitations," Section 6.

To obtain Eyewear benefits, you must go to a Participating Eyewear Dispenser.

Eyewear benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care LLC, a vision services provider panel, to provide and administer Eyewear benefits. EyeMed Vision Care provides benefits for eyewear through a network of dispensing opticians and optometric laboratories. Vision examinations are provided through your Physician Group or you may schedule a vision examination through EyeMed Vision Care. Refer to "Office Visits" in "Schedule of Benefits and Copayments," Section 3, for information on vision examinations.

If you require eyeglasses, a prescription is written, and you are free to purchase eyewear from a list of contracting dispensing opticians in California. The optician will bill EyeMed Vision Care for reimbursement. If you select standard lenses and frames, you will not owe the dispensing optician. But if more costly items are selected, you are required to pay the amount in excess of those specified in "Eyewear Allowance" in "Schedule of Benefits and Copayments," Section 3. Only Eyewear services obtained through contracting providers are covered.

To find a Participating Eyewear Dispenser, contact the Health Net Vision Program at 1-866-392-6058 or visit our website at www.healthnet.com/uc.

Eyewear obtained from nonparticipating dispensers is not covered.

Eyewear benefits are provided by the Health Net Vision Program and are administered by EyeMed Vision Care, LLC.

The following benefits are provided for Eyewear:

Lenses

- One pair of standard plastic eyeglass Lenses are covered during a 24-month period.

- One pair of Medically Necessary Contact Lenses or Contact Lenses chosen for convenience or cosmetic purposes is covered during a 24-month period. The maximum allowable amount is shown in "Schedule of Benefits and Copayments," Section 3. If disposable Contact Lenses are used, you should submit only one claim after the charges for the individual pairs of Lenses reach the allowable amount shown in "Schedule of Benefits and Copayments," Section 3.

Medically Necessary Contact Lenses

Medically Necessary Contact Lenses are Lenses that meet any of the following specifications:

- They are necessary because of keratoconus, when visual acuity cannot be corrected to 20/40 with the use of spectacles.
- They are prescribed following cataract surgery and the natural lens is not replaced with a lens implant (aphakia).
- They are necessary because of anisometropia 3 diopters or more, provided visual acuity improves to 20/40 or better in the weaker eye.

- They are necessary because of astigmatism of 3 diopters or more.
- They are necessary because of hyperopia of greater than 7 diopters.
- They are necessary because of myopia of greater than 12 diopters.

Tints

Solid or gradient tint options are covered up to the amount shown in "Schedule of Benefits and Copayments.

Eyeglass Frames

One set of Frames are covered up to the amount shown in "Schedule of Benefits and Copayments," Section 3.

6. 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.

Services and Supplies

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 5, 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 7, 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 5.

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 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 coverage through this Plan has ended are not covered, except as specified in "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 1.

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.

Medical Services and Supplies

In addition to the exclusions and limitations shown in "Services and Supplies" portion of this section, the following exclusions and limitations apply to services and supplies under the medical benefits and the Mental Disorders and Substance Abuse 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 7, 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 9). 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

Injectable contraceptives (which are administered by a Physician) are covered as a medical benefit. If your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA approved contraceptive method as prescribed by your Physician.

Services related to Norplant are limited to the removal only. Norplant devices are not covered.

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, hairpieces 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
- 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.

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

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 2, 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.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental conditions
- 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 5).

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

Durable Medical Equipment

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).
- Support appliances such as stockings, over the counter support devices or Orthotics, and devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics, that are not custom made to fit the Member's body.
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Corrective footwear (such as corrective shoes or foot Orthotics) that is not incorporated into a cast, brace or strapping of the foot, unless it is Medically Necessary for the management and treatment of diabetes.

The Plan covers Medically Necessary diabetic equipment as shown in "Medical Supplies" portion of "Schedule of Benefits and Copayments," Section 3 and "Diabetic Equipment" portion of "Covered Services and Supplies," Section 5. 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 5.

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

Genetic Testing and Diagnostic Procedures

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

Home Birth

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

Noncovered Treatments

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

- 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 (including insulin), 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 unless listed in the Recommended Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s) will only be covered when Prior Authorization is obtained from Health Net.

Outpatient Prescription Drugs

Outpatient Prescription Drugs benefits are not covered under this medical Plan. Please refer to the separate Medicare Prescription Drug Plan Evidence of Coverage included with this mailing. You can also obtain a copy at www.healthnet.com/uc.

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 5.

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. Shift care and any portion of shift care services are also not covered

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 Substance Abuse.

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 7, 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.

Erectile Dysfunction Drugs
Drugs (including injectable medications) prescribed for the treatment of erectile dysfunction are not covered under this medical Plan. Please refer to the separate Medicare Prescription Drug Plan Evidence of Coverage included with this mailing. You can also obtain a copy at www.healthnet.com/uc.

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).

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 9.

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.

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 Substance Abuse).

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

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 Substance Abuse) 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.

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

Chiropractic Services and Supplies
The exclusions and limitations in the "Services and Supplies" and "Medical 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 5, 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 Neuromusculoskeletal 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 are not covered.

Eyewear

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Eyewear.

Note: Services or supplies excluded under the Eyewear 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 5, for more information.

Additional exclusions and limitations:

Refraction Exams

Refraction exams are not covered except as stated in "Medical Services and Supplies," Section 5.

Aniseikonic Lenses

Lenses that correct the vision defect known as aniseikonia are not covered.

Medical Treatment

Diagnostic services and medical or surgical treatment of the eye are not covered. Please see "Medical Services and Supplies" portion in "Covered Services and Supplies," Section 5, for information.

Nonparticipating Dispensers

Services or supplies provided by a dispenser other than a Participating Eyewear Dispenser are not covered.

Nonprescription Eyewear

Nonprescription vision devices and sunglasses are not covered.

Optional Frames

Additional fitting and measurement charges or special consultation charges due to the purchase of optional Frames, are not covered.

Orthoptics

Orthoptics or vision training are not covered.

Drugs

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

Vision Aids

Vision aids (other than Eyeglasses or Contact Lenses) are not covered.

Progressive Lenses

The Eyewear allowance for Progressive Lenses is the same as for trifocal Lenses. Any difference between that and the retail price is your responsibility.

7. General Provisions

When the Plan Ends

The Standardized Contract specifies how long this Plan remains in effect.

If you are totally disabled on the date that the Standardized Contract is terminated, benefits will continue according to "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 1.

When the Plan Changes

Subject to notification and according to the terms of the Standardized Contract, 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 Standardized Contract. Notice of modification will be sent to the Group. Except as required under "Eligibility, Enrollment and Termination" Section 1, 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 Standardized Contract 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.

Member Services Department Interpreter Services

Health Net's Member Services Department has bilingual staff and interpreter service for additional languages to handle Member language needs. Examples of interpretive services provided include explaining filing a grievance benefits 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/uc;
- File a complaint if your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding Health Net's Member rights and responsibilities policies.

Members have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon on with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Grievance, Appeals, Independent Medical Review 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, including an adverse benefit determination as set forth under the Patient Protection and Affordable Care Act (PPACA). An adverse benefit determination means a decision by Health Net to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of a individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or

- An exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Member Services Department at 1-800-539-4072 or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com/uc.

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

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

If your concern involves the Mental Disorders and Substance Abuse program call Managed Health Network (MHN) at 1 888 426-0030, or write to:

Managed Health Network
Attention: Appeals & Grievances
P.O. Box 10697San Rafael, CA 94912

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 he 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 1-800-539-4072.

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 1-800-539-4072.

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 1-800-539-4072 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 provide for judicial review of arbitration proceedings.

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

Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

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.

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.

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
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties 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.

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 9, 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.

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 the "Government Coverage" portion of this "General Provisions," Section 7.)

   (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 or 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 "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.

Government Coverage Medicare

If Medicare has made primary payment or is obligated to do so according to federal law and Health Net has provided services, Health Net will obtain reimbursement from Medicare, any organization or person receiving payments to which Health Net is entitled.

Medi-Cal

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

Veterans' Administration

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

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.

8. 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 14703
Lexington, KY 40512

If you need to file a claim for Emergency Mental Disorders and Substance Abuse, or for other covered Mental Disorders and Substance Abuse Services provided upon referral by Managed Health Network (MHN), you must file the claim with MHN 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 is was not reasonably possible to file the claim within one year, and that is was filed as soon as reasonably possible. You must use the CMS (HCFA) - 1500 form in filing the claim, and you should send the claim to MHN at the address listed in the claim form or to MHN at:

Managed Health Network
P.O. Box 14621
Lexington, KY 40512-4621

MHN will give you claim forms on request. For more information regarding claims for covered Mental Disorders and Substance Abuse Services, you may call MHN at 1-800-444-4281 or you may write MHN 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 2.

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/uc. 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 and Managed Health Network (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 behavioral 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/uc. 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: 1-800-539-4072

Fax: 1-818-676-8981
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.

9. 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.

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.

Behavioral Health Administrator is a specialized health care service plan which contracts with Health Net to underwrite and administer delivery of Mental Disorders and Substance Abuse services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities. Health Net has contracted with Managed Health Network (MHN) to be the Behavioral Health Administrator.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

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 3.

Corrective Footwear is special footwear that is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

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.)

In the alternative, a person of the opposite sex under age 62 who is the Domestic Partner of the Subscriber is eligible for coverage provided that the partnership meets requirements 1 through 5 above.

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
- 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 personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate, the Psychiatric Emergency medical Condition, either within the capability of the facility or by transferring the Member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as Medically Necessary.

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 Independent Medical Review of a Plan denial of coverage for Emergency Care.

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.

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 Standardized Contract to provide the benefits of this Plan.

Standardized Contract 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 (including any portion of shift care services) is not covered under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enter ally 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.

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.

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.

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.

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.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. 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 4.

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 Mental 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 the Behavioral Health Administrator, to provide Mental Disorder and Substance Abuse benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Substance Abuse 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 the Behavioral Health Administrator to provide Mental Disorder and Substance Abuse 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 Standardized Contract 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.

Prior Authorization is Health Net's approval process for certain Level I, Level II or Level III Drugs that require pre-approval. Member Physicians must obtain Health Net's Prior Authorization before certain Level I, Level II or Level III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a hospital or skilled nursing facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services

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

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be

offered to improve their level of functioning in the community. Health Net requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

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

Serious Emotional Disturbances of a Child 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.

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.

Substance Abuse is alcoholism, drug addiction or other substance abuse problems.

Substance Abuse Care Facility is a Hospital, residential treatment center, structured outpatient program, day treatment or partial hospitalization program or other behavioral health care facility that is licensed to provide Substance Abuse detoxification services or rehabilitation services.

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.

UC Standardized Contract is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

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.

10. 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，請按您會員卡上所列的電話號碼，個人與家庭計畫會員請按 800-839-2172。
僱主團體會員請按 800-522-0088。健康家庭計畫會員請按 888-231-9473。
Chinese

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

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

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

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը բարձրաձայն ձեզ հասնող ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) առանձի վրա նշված համարով, իսկ եթե Անհատական և Ընտանեկան անդամ եք, խնդրում ենք զանգահարել 800-839-2172 համարով: Գործատուների 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 вам 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

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